

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5760

CERTIFICATE OF DEATH

Reg. Dist. No.

4

M
Correct age

1. PLACE OF DEATH:

County..... Allegany.....

City or town..... Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Eight Months

Hospital, institution, or street address where death occurred:

807 Maryland Ave.

How long in hospital or institution?.....

3. (a) FULL NAME

Earnest Van Adams

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife..... Olive Rachel Edwards Adams

7. Birth date of deceased (mo. day. yr.) 6. (c) If alive, give age 55 years

8. AGE: Years Months Days If less than one day
58 0 21 hrs. min.9. Birthplace..... Connellsburg Pa.
(Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business General Box Co

12. Name..... William H. Adams

13. Birthplace..... Brownsville Pa.

14. Maiden name..... Minnie Crawford

15. Birthplace..... Brownsville Pa.

16. Informant Mrs. Ernest V. Adams (wife)

Address..... Cumberland Md.

17. Burial Date thereof..... 6/22/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Hill Grove Cemetery

Location..... Connellsburg, Pa.

18. Funeral director..... Charles McCorquick

Address..... Connellsburg, Pa.

19. Date rec'd by registrar..... June 21, 1948 W.H. Fahey M.D.

(Date rec'd by registrar) (Signature) (Title) (Address)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 807 Maryland Ave

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

376-09-2269

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 19 1948 a.m. 3.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive Dead June 19 1948

Immediate cause of death.....

Massive pulmonary hemorrhage

DURATION

about 3 minutes

Due to bronchogenic carcinoma of the upper left hilum

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

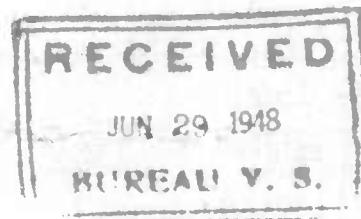
Means of injury..... Injured at work?

Deputy Medical Examiner - Allegany Co. M. D. Deming M.D.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. Deming M.D.

Address..... Cumberland Md. Date signed 6-19-48



M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

458

5701

CERTIFICATE OF DEATH

Reg. Dist. No. /

1. PLACE OF DEATH:

County Allegany

City or town Little Orleans

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Minnie Agnes Appel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife John Frederick

Appel 6. (c) If alive, give age — years
7. Birth date of deceased (mo. day. yr.) July 29, 1871

8. AGE: Years 76 Months 10 Days 15 If less than one day — hrs. — min.

9. Birthplace Little Orleans, Allegany Co., Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name Cromwell Stattlermyer

13. Birthplace West Virginia

14. Maiden name Louiscanna Brady

15. Birthplace Timber Ridge, Wash Co., Md.

16. Informant Mason A. Appel

Address Little Orleans, Md.

17. Burial Date thereof June 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or embalming Little Orleans Meth

Location Little Orleans, Md.

18. Funeral director Charles R. East

Address Hancock, Md.

19. June 17, 1948 Mrs. J. A. Wilson
Date rec'd by registrar Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Little Orleans
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1948 21 8 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/11/1947 to May 15, 1948 and that I last saw her alive on May 21, 1948.

Immediate cause of death Carcinoma Tongue DURATION

Due to: —

Due to: —

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. —

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

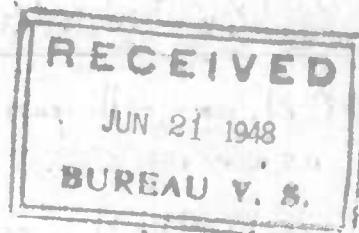
23. SIGNATURE R. Rice Rosebone M. D. or other

Address 122 So Centre Date signed 6-15-48

Date rec'd by registrar

7 17 44
1948-8-X4
1871-7-29

76-10-16



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. P. E. Berry

468
Reg. Dist. No. 6

5702

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, institution, or street address where death occurred:

113 Jamisson St.

How long in hospital or institution? - - - - -

3. (a) FULL NAME

ELIZABETH ANN BECK

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Frederick H. Beck

7. Birth date of deceased (mo., day, yr.)

February 29, 1876

6. (c) If alive, give age - - - years

8. AGE: Years

72

Months

3

Days

13

If less than one day

hrs.

min.

9. Birthplace

Luke, Allegany, Maryland

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Own home

MOTHER FATHER

12. Name

John H. Jones

13. Birthplace

Wales

14. Maiden name

James Parcell

15. Birthplace

Wales

16. Informant

William Beck

Address

Westernport, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May June 11, 1948
(month) (day) (year)
Philos Cemetery

Cemetery or crematory

Westernport, Maryland

Location

Ellsworth S. Boal

18. Funeral director

Westernport, Maryland

Address

19. Date rec'd by registrar

June 10 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 152 Wood St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1948 at 6:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1-1948 to June 8 1948

and that I last saw her alive on June 8 1948

Immediate cause of death

Carcinoma of Stomach

DURATION

1 yr.

Due to

Intestinal Obstruction

2 mo.

Due to

Atherosclerosis

5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

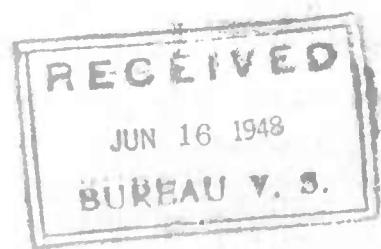
Means of Injury

Injured at work?

23. SIGNATURE

P. E. Berry M.D. M. D. or other

Address Piedmont Dr. W. Date signed 6/9/48



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

5703
4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68-3-13

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 1 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1912 Rachamis St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

217-107-815

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6 1948 to June 10 1948
and that I last saw him alive on June 10 1948

Immediate cause of death

cancer of the stomach

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cancer of the stomachDate of op. 6-1-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

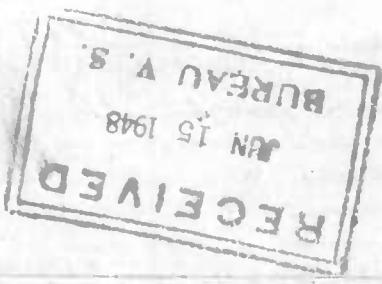
23. SIGNATURE

L. Kline MD

M. D. or other

Address

Date signed



Stein

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

CERTIFICATE OF DEATH

Reg. Dist. No.

45704

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 47 DAYS

3. (a) FULL NAME

MRS. JENNIE BIRMINGHAM

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOWED

6.(b) Name of husband or wife

JOHN BIRMINGHAM

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

MARCH 3, 1871

8. AGE:

Years
77Months
3Days
14

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

MOTHER FATHER

MATHEW FLANNIGAN

13. Birthplace

IRELAND

14. Maiden name

ELIZABETH HAGGERTY

15. Birthplace

ENGLAND

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE., CITY

17. Burial

Date thereof 6/19/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Patricks Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

June 18 1948

A. D. Trautz, M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 CHARLES ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 17,

19. 48, at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 12 1948 to June 17 1948 and that I last saw her alive on June 17 1948.

Immediate cause of death

Cachexia

Due to Squamous cell carcinoma of rectum

Due to generalized metastasis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

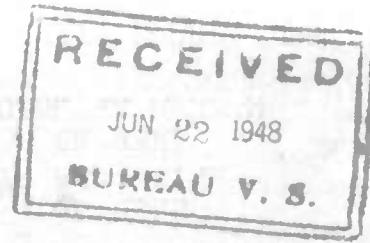
Means of injury

Injured at work?

23. SIGNATURE

George M. Kight M. D. or other

Address Memorial Hospital Date signed 6/17/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 61 Murray 785 10

1. PLACE OF DEATH:

County

Allegany

City or town Mr. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cemetery Rd.

How long in hospital or institution?

3. (a) FULL NAME

Katherine Braier

4. Sex

Female

5. Color or race

White Single

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 28, 1893

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

54

7

8

9. Birthplace

Mt. Savage Md.

(Town, county, and state)

10. Usual occupation

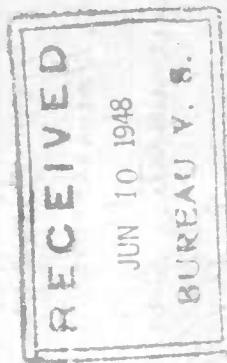
Housework

11. Industry or business

Home

MOTHER FATHER

Dr Murray.



Within corporate limits
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

838

5706

CERTIFICATE OF DEATH

Reg. Diat. No.

4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, Institution, or street address where death occurred:

729 Bedford St.

How long in hospital or institution?

3. (a) FULL NAME

Mrs Mary Elizabeth Bratt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

Arthur Wm Bratt

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

March 27 1869

8. AGE: Years Months Days If less than one day

79 2 6 hrs. min.

9. Birthplace Baltimore, Baltimore, Md.

(Town, county, and state)

10. Usual occupation Housework

at Home

11. Industry or business

Wm Bratt Fancy

12. Name

Baltimore, Md.

13. Birthplace

Mary E. Tracey

14. Maiden name

Baltimore, Md.

15. Birthplace

Mrs. Carl Murray

16. Informant

Address 729 Bedford St. Cumberland, Md.

17. Burial

(Burial, cremation, or removal, Which?) Cemetery or crematory

Date thereof June 5, 1948

(month) (day) (year)

Cemetery Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. O'Hanlon

Address Cumberland, Md.

19. June 5, 1948

(Date rec'd by registrar)

W.H. Tracy M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 729 Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 3, 1948, at 7:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31, 1948, to June 3, 1948,

and that I last saw her alive on June 3, 1948.

Immediate cause of death

Cerebral Hemorrhage

DURATION 4 days

Due to Cerebral Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

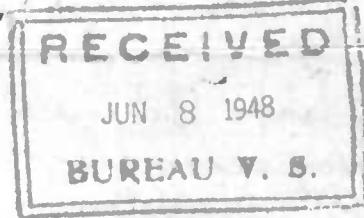
Means of injury Injured at work?

23. SIGNATURE

H. Gleason M.D.

156 North Cumberland St. Date signed

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5707

8

Reg. Dist. No.

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County

City or town

Allegany
Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

59 years 1 month 26 days

Hospital, institution, or street address where death occurred:

Furnace Street

How long in hospital or institution?

none

3. (a) FULL NAME

James Barber Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Florence Liddy

6. (c) If alive, give age

59

years

7. Birth date of deceased (mo. day yr.)

Sept. 15, 1888

8. AGE:

Years

Monthly

Days

If less than one day

59

8

20

hrs.

min.

9. Birthplace

Lonaconing, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation

Cemetery Worker

11. Industry or business

Oak Hill Cemetery Lonaconing Md.

MOTHER FATHER

12. Name

William Brown

13. Birthplace

Lonaconing Md.

14. Maiden name

Margaret Reed

15. Birthplace

Lonaconing Md.

16. Informant

Mrs. Jas. Brown

Address

Lonaconing, Md.

17. Burial

Date thereof June 7, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Oak Hill Cemetery

Location

Lonaconing, Md.

18. Funeral director

Mr. Eichhorn

Address

Lonaconing, Md.

19. Date rec'd by Registrar

June 9, 1948

(Date rec'd by Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

G.W.C.

3. (b) Social Security Number

216-05-5864

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 5

1948 at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4

1948 to June 5, 1948

and that I last saw him alive on June 4, 1948

Immediate cause of death

Chronic Myocarditis

DURATION

2 wks

Due to

Due to

Other conditions Generalized Anasarca

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Norman Reiner M.D. M. D. or other

Address Westernport Md. Date signed 6/17/48

RECEIVED

JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5788
1071

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

ALLEGANY

County

CUMBERLAND

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 5 DAYS

3. (a) FULL NAME

MASTER EARL BRETT

Bryte, Jr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

INFANT

6. (b) Name of husband or wife.....

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

MARCH 12, 1948

8. AGE: Years

3

Months

18

Days

If less than one day

hrs.

min.

9. Birthplace

W. VA

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name

EARL BRETT

13. Birthplace

W. VA

14. Maiden name

LOVA EVERLY

15. Birthplace

W. VA

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE.

17. Burial

Date thereof July 1, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Grandonville

Location

Braxtonville, W. Va.

18. Funeral director

E. S. Harned

Address

Braxtonville, W. Va.

19. Date rec'd by registrar

June 30, 1948

W. R. Dauby, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA

County

PRESTON

City or town BRISTOL MILLS

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 30

19 48 at 12:20 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25, 1948, to June 30, 1948,

and that I last saw h. f. m. alive on June 30, 1948.

Immediate cause of death

Tuberculosis, left lower lung, emphysema, left lower

Due to

Pneumonia, Bronchitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George M. Seamon

M. D. or other

Address Memorial Hospital Date signed 6/30/48

RECEIVED
JUL 8 1948
BUREAU V. S.

Within corporate limits
Weisman

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

Allegany Hospital

2 Days

How long in hospital or institution?.....

3. (a) FULL NAME

Katherine Maus Buckler

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Paul T. Buckler

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1884 1874

8. AGE: Years Months Days If less than one day

73 9 8 hrs. min.

9. Birthplace Cumberland, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Matthais Maus

13. Birthplace Alsace Lorraine

14. Maiden name Mary A. Zapf

15. Birthplace Cumberland, Md.

16. Informant Mrs. Paulvera Ratigan

Address 110 Bedford St. Cumberland, Md.

17. Burial Date thereof June 14, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory S.S. Peter & Paul Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Date rec'd by registrar June 13, 1948

(Date rec'd by registrar) W.R. Tracy, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1948, 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6, 1948, to June 10, 1948,

and that I last saw her alive on June 9, 1948.

Immediate cause of death Myocardial infarction

DURATION 3 days

Due to Coronary occlusion

Other conditions Arteriosclerosis & Hypertension

Other conditions Heart disease

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

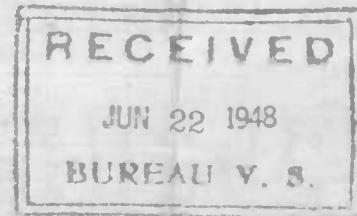
Means of injury Injured at work?

23. SIGNATURE June 13, 1948

M. D. or other

Date signed

6/3
1947
1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5710

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

Allegany

City or town

Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all her life in Ohio

Hospital, institution, or street address where death occurred:

Miners Hospital, Frostburg Md.

How long in hospital or institution?

21 hrs.

3. (a) FULL NAME

Mrs. Edna Burris

4. Sex

Female

5. Color or race

White widow

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Edmund Burris

7. Birth date of deceased (mo., day, yr.)

Aug 11 1870

8. AGE:

Years

Months

Days

If less than one day

77

9

16

hrs.

min.

9. Birthplace

Mo. Pleasant Ohio

(Town, county, and state)

10. Usual occupation

Stonecutter

11. Industry or business

Thomas P. Gorsuch

12. Name

Thomas P. Gorsuch

13. Birthplace

Unknown

14. Maiden name

Mary McMaster

15. Birthplace

Unknown

16. Informant

(Son) Mrs. Burris

Address

Mo. Pleasant, Ohio

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6-29-48

(month) (year)

Cemetery or crematory

Highland Cemetery

Location

Mo. Pleasant, Ohio

18. Funeral director

Jacob Hager

Address

Frostburg, Md.

19. Date rec'd by registrar

6/27/48

1948

Mrs. C. Price

acting

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Ohio

County

Jefferson

City or town

Mo. Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 27

1948

a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

and that I last saw h.

Dead June 27

1948

Immediate cause of death

Coronary Thrombosis and

shock

Due to

Fracture of left femur & posterior

tibia & fibula right leg lower third

Due to

Automobile accident 6/26/48

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Auto accident

Date of

6/26/48

Where did injury occur?

Frostburg Allegany

(City or town)

Md.

(State)

Injured at home, farm, industry, public place (where?)

East Main & Grant St

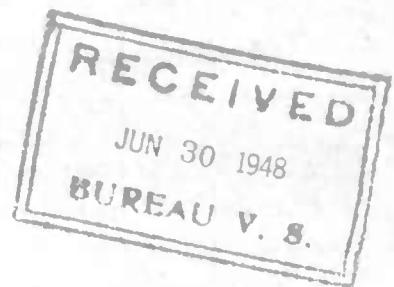
Crash into car by auto

Means of injury

Medical Examiner

Injured at work

Legally vs



Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5711

92d

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Allegany

County

Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 years

Hospital, institution, or street address where death occurred:

1013 Bedford Street

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Susan Casteel

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

Shadwick Casteel

6.(b) Name of husband or wife

6.(c) If alive, give age .. years

7. Birth date of deceased (mo. day yr.)

March 18, 1870

8. AGE: Years

278

Months

2

Days

13

It less than one day

hrs.

min.

9. Birthplace: Centreville, Bedford Co. Pennsylvania

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name: George Hause

13. Birthplace: Bedford Co. Pennsylvania

14. Maiden name: Amy Hendrickson

15. Birthplace: Bedford Co. Pennsylvania

16. Informant: Mrs. Anna Kimmel

1013 Bedford Street, Cumberland, Maryland

17. Burial

Date thereof: June 3, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Luthern Cemetery

Location: Centreville, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Maryland

19. Date rec'd by Registrar: June 3, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County

Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1013 Bedford Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 1st 1948 at 10 a.m.

May 29th 1948

and that I last saw her alive on May 31st 1948

Immediate cause of death

acute myocarditis

Due to: chronic endocarditis

Due to: hypertension

Other conditions: hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. L. Owens M.D.

M. D. or other

Address: Cumberland, Md. Date signed: 6-2-48

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5712

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH:

County..... Allegheny
City or town..... Cumberland Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

305 South Allegany Street

How long in hospital or institution?

3. (a) FULL NAME

Samuel L. Cessna

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Elsie Anderson Cessna

7. Birth date of deceased (mo., day, yr.) Oct. 9th. 1871

8. AGE: Years Months Days If less than one day
76 Yrs. 8 mos 11 das. hrs. min.9. Birthplace..... Oberain Twp., Bedford Co., Pa.
(Town, county, add state)

10. Usual occupation..... Farmer - Retired

11. Industry or business

12. Name William Cessna

13. Birthplace Bedford Co., Pa.

14. Maiden name Rachel Rose

15. Birthplace Bedford Co., Pa.

16. Informant Bedford Co., Pa.

Address Elsie A. Cessna, Cumberland

17. Burial Cemetery or crematory Memorial Park, Bedford, Pa.

(Burial, cremation, or removal. Which?) Date thereof June 23rd, 1948

(month) (day) (year)

Location 305 S. Allegany Street

18. Funeral director Fred C. Pato - Son.

Address # 203 So. Juliana St., Bedford, Pa.

19. Date rec'd by registrar June 20, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Allegany
City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 South Allegany Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1948 at 7 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 1948, to June 19, 1948, and that I last saw him alive on June 19, 1948.

Immediate cause of death Cerebral Hemorrhage

DURATION 24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

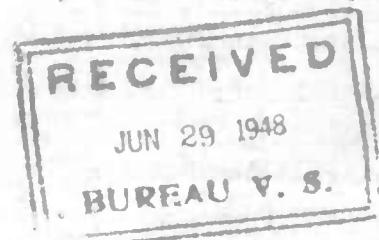
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. J. Rees, M.D. M. D. or other

Address 404 Decatur St. Date signed 6/22/48



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5713

93d

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

76 Years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Sylvan Retreat

30 Days

How long in hospital or institution?

3. (a) FULL NAME

Augusta Chandler

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

Cornelius C Chandler

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25 1872

8. AGE: Years Months Days If less than one day

75 9 14 hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation House

11. Industry or business

12. Name Frederick Yeager

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Charles B. Conners

Address 481 Goethe St, Cumberland, Md

17. Burial Date thereof 6/12/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Lukes Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Date rec'd by registrar June 12 1948

John Trautz M.D. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 332 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 1948 to June 9 1948

and that I last saw her alive on June 9 1948

Immediate cause of death

Myocardial failure

Due to Chronic myocarditis +
cardiac hyper trophyDue to Myo perithoracic vascular
disease.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

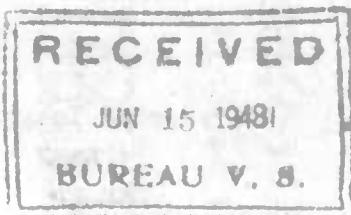
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 110 S. Centre St. Date signed 6-11-48



DR. HODGES
Within corporate limits
XXXXXX

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

5714

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

1 DAY

How long in hospital or Institution?

3. (a) FULL NAME

COBY, BABY BOY DIXON LEE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

JUNE 17, 1948

8. AGE: Years Months Days If less than one day

1 DAY

/ hrs. min.

9. Birthplace MARYLAND, CUMBERLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER COBY, JOHN D.

13. Birthplace W.VA.

14. Maiden name KESSELL, GENEVIEVE C.

15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MARYLAND

17. BURIAL Date thereof June 19, 1948
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or location SCOTT'S CEMETERY,

Location DURGON, W.VA.

18. Funeral director P. E. THRUSH

Address MOOREFIELD, W.VA.

19. Date rec'd by registrar June 19, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

STATE ALLEGANY

COUNTY HARDY

CITY OR TOWN MOOREFIELD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18, 1948

19. 7:15 Pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17, 1948, to June 18, 1948

and that I last saw him alive on June 18, 1948

Immediate cause of death Preaturity.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

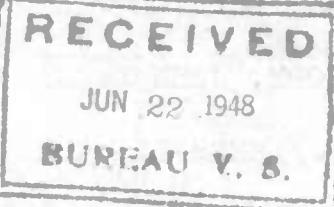
Injured at work?

23. SIGNATURE

W. P. Hodges, M.D.
Cumberland, Md.

M. D. or other

Date signed



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5715

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County.....

Allegany
Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

60 - 1 - 18

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?.....

9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County Allegany

City or town.....

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 S. Walnut Place

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret E. Combs

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored Widowed

6.(a) Single, married, widowed, or divorced

Ernest L. [redacted] Combs

6.(b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

May 11 1888

6.(c) If alive, give age..... years

8. AGE: Years

Months Days If less than one day

60 1 18 hrs. min.

9. Birthplace.....

Cumberland Md.

(Town, county, and state)

10. Usual occupation.....

House work

11. Industry or business

Daniel Bromberg

12. Name.....

Ord.

13. Birthplace

Francis Harper

14. Maiden name.....

Ord.

15. Birthplace

Mrs. Garrison Brothers

16. Informant.....

Cumberland

Address

Burial

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland

18. Funeral director.....

Louis Stein Inc.

Address

Cumberland

19. Date rec'd by registrar.....

19. 48

(Date rec'd by registrar)

L. A. Frank, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 29 1948 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1948 to June 29 1948

and that I last saw her alive on June 28 1948

Immediate cause of death.....

Cerebral

Due to.....

Chronic nephritis

Due to.....

Other conditions.....

(Include pregnancy within 2 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

L. A. Frank, M.D.

M. D. or other

Address.....

59 Second St. Date signed 6-28-48

RECEIVED
JUL 8 1948.
BUREAU F. B. I.

Within state limits.

DR. BROADRUP

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5716

Reg. Dist. No. 4

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County..... ALLEGANY

City or town..... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 155 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 155 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County..... ALLEGANY

City or town..... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 E. SECOND ST

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

217-10-7603

3. (a) FULL NAME

HENRY J CONWAY

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) JAN 8, 1877

8. AGE: Years 71 Months 4 Days 24 If less than one day hrs. min.

9. Birthplace NEW YORK
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

MOTHER FATHER 12. Name JAMES CONWAY

13. Birthplace IRELAND

MOTHER 14. Maiden name ELLEN GEARY

15. Birthplace IRELAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVENUE

17. Burial Date thereof Jan 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter's & Paul's Cem.

Location Cumberland Md.

18. Funeral director Louis Stein, D.S.

Address Cumberland Md.

19. Date rec'd by registrar June 2, 1948 W.H. Kraut, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 2

1948 at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Xeceptor 30 1948 to June 2 1948

and that I last saw him alive on June 2 1948

Immediate cause of death

Chronic Myocarditis 2 years

Due to Essential Hypertension 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

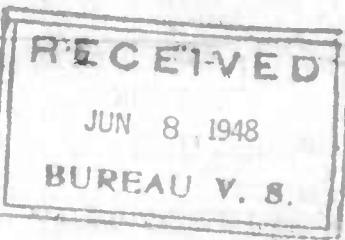
Means of injury

Injured at work?

23. SIGNATURE

J.P. Broadrup, M.D. A.D. or other

Address Cumberland Md. Date signed 6-2-48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

5717

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 days.

Hospital, institution, or street address where death occurred:

713 S. Mechanics St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Henrietta Gerdeman

7. Birth date of deceased (mo., day, yr.)

Oct 18 1876

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day
71 8 11 hrs. min.

9. Birthplace

Newark, Ohio.

(Town, county, and state)

10. Usual occupation

Traffic representative

11. Industry or business

R. A. Co Retired

MOTHER FATHER

12. Name James A. Cook

13. Birthplace And.

14. Maiden name Annie Smith

And.

15. Birthplace

Drs Russell & Conter

Cumberland

Address

Bush

Date thereof July 1, 48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland.

18. Funeral director

Louis Stein Inc

Address

Cumberland

19. Date rec'd by registrar

June 30, 1948

W. Dauty, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Allegany.

City or town

Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.

713 S. Mechanics St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

717-14-1689

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 29 1948 at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1948 to June 29 1948

and that I last saw him alive on June 26 1948

Immediate cause of death

Carcinoma

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. Bailey Hunter M.D.

M. D. or other

Address Cumberland Md. Date signed 6/29/48

RECEIVED
JUL 8 1948
BUREAU V. S.

Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5718
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:
County... Allegany

City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
964 Glenwood St.

How long in hospital or institution?

3. (a) FULL NAME

Vergie Cornelius

4. Sex F	5. Color or race W	6. (a) Single, married, widowed, or divorced Married
----------	--------------------	--

6. (b) Name of husband or wife Wilbur Cornelius

7. Birth date of deceased (mo., day, yr.) May 26, 1896

6. (c) If alive, give age years

8. AGE: Years 52 Months I Days I If less than one day hrs. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

MOTHER FATHER 12. Name Charles S. Smith Miller

13. Birthplace Md.

14. Maiden name Grayson May Ann Garrison

15. Birthplace Virginia Md.

16. Informant Mrs. Virginia Mc Millin

Address 964 Glenwood, St

17. Burial Date thereof June 30, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Cumberland, Md.

18. Funeral director James E. Scarpelli

Address 108 Virginia Ave

19. June 28, 1948 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)

State... Maryland County... Allegany

City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 964 Glenwood St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Number 318-16-3949

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5, 1948 to May 29, 1948

and that I last saw her alive on May 29, 1948

Immediate cause of death

DURATION

Myocarditis, Show, P.M.

Other causes of death

Other conditions

Include pregnancy within 6 months of death

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

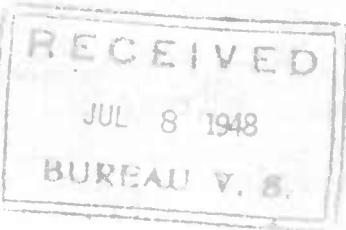
Injured at work?

23. SIGNATURE

M. D. or other

Date signed 6/28/48

Address



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5719

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 DAYS

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 65 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA

County GRANT

City or town GORMANIA W. VA

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

HIRAM B COTTRILL

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.) DEC. 20, 1865

8. AGE: Years 82 Months 7 Days 20 If less than one day hrs. min.

82 7 20 hrs. min.

9. Birthplace (Town, county, and state) Harrison County W. Va.

10. Usual occupation Coal operator

11. Industry or business

12. Name WILLIAM COTTRILL

13. Birthplace W. VA

14. Maiden name COFFMAN MARY JANE

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE

17. Burial Date thereof June 19, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or location Copeland

Near Salem N. Y.

Location Near Salem N. Y.

Location P. E. Thrush and Son

Funeral director Petersburg Co. Va.

Address

Date rec'd by registrar June 19, 1948

Lab. Dr. Hantz M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA

County GRANT

City or town GORMANIA W. VA

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 10, 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

4-16-1948 to 6-10-1948

and that I last saw him alive on 6-9-1948

Immediate cause of death

Carcinoma of Prostate

Due to with multiple metastases

Duration

Due to

Other conditions Arteriosclerosis

Myocardial degeneration

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results as above Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

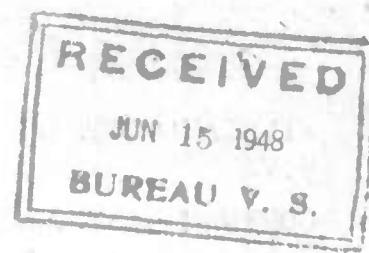
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard Tolson, M.D. M. D. & other

Address Cumberland, Md. Date signed June 10, 1948



Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

5720

Reg. Dist. No.....

4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
City or town near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:
R. F. D. # 2

How long in hospital or institution?

3. (a) FULL NAME

Mrs Virgie Elizabeth Craftie Young

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Willard Craftie

6.(c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) July 29, 1901

8. AGE: Years 46 Months 10 Days 20 If less than one day hrs. min.

9. Birthplace Kifer, Allegany Co Md
(Town, county, n. state)

10. Usual occupation Housewife

11. Industry or business Andrew Robertson

MOTHER FATHER 12. Name... Andrew Robertson

13. Birthplace Kifer, Md

14. Maiden name Martha Robig

15. Birthplace Kifer, Md

16. Informant Paul Craftie

Address Rt #2 Cumberland Md.

17. Burial Date thereof June 22, 1948
(Burial, cremation, or removal, which?)

Cemetery or crematory Mt Hermon Methodist

Location Near Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md

19. Date rec'd by Registrar June 23, 1948 W. Franky, M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town near Cumberland (Md.)
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. # 2
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 66 to June 19, 1948

and that I last saw her alive on June 17, 1948

Immediate cause of death Cerebrovascular accident

with generalized convulsions

Due to 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

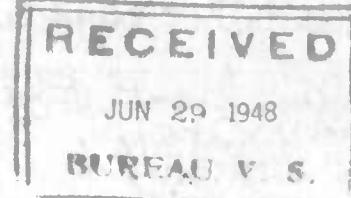
Means of injury Injured at work?

23. SIGNATURE James J. Johnson, M.D.

M. D. or other

Address Cumberland Md Date signed 6-25-48

M. B Schindler



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5721

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....

Allegany

City or town.....

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 days

Hospital, Institution, or street address where death occurred:

Allegany County Hospital

How long in hospital or institution?.....

4 days

3. (a) FULL NAME

James Crosser

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife..... Margaret Robertson

7. Birth date of deceased (mo., day, yr.)

March 29, 1865

6. (c) If alive, give age..... years

83 2 16

8. AGE: Years Months Days If less than one day

hrs. min.

9. Birthplace.....

Larkhall, Scotland

(Town, county, and state)

10. Usual occupation.....

Mining

11. Industry or business.....

Pekin Mine, Rosaceous

12. Name..... John Crosser

13. Birthplace.....

Scotland

14. Maiden name..... Elizabeth Barr

15. Birthplace.....

Scotland

16. Informant.....

Henry Crosser

Address.....

Rosaceous, Md.

17. Burial Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Oak Hill Cemetery

Location.....

Rosaceous, Md.

18. Funeral director.....

M. Eichhorn

Address.....

Rosaceous, Md.

19. Date rec'd by registrar.....

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Allegany

City or town..... Rosaceous

(If outside city or town limits, write RURAL and give nearest town)

Street No..... West Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 14 1948 at 8:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1948 to June 14 1948

and that I last saw him alive on June 12 1948

Immediate cause of death.....

Myocardial failure

DURATION 10 min

Due to..... Chronic myocarditis

4 yrs

Due to..... Senility

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

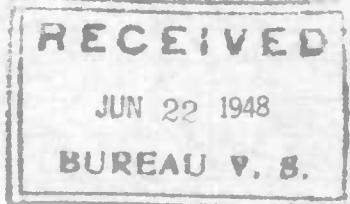
Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Arthur Dales M.D.

M. D. or other

Address..... 110 S. Centre St. Date signed 6-15-48



PLEASE WRITE PLAINLY WITH EXADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5722

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Joseph Curley

3. (b) Social Security Number

214-01-3688

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White Married

6. (b) Name of husband or wife

Mary Bryson

7. Birth date of deceased (mo., day, yr.)

July 2nd 1886

6. (c) If alive, give age 60 years

8. AGE:

Years

Months

Days

If less than one day

61 11 25 hrs. min.

9. Birthplace

Carls, Allegany

(Town, county, and state)

10. Usual occupation

Kelly Springfield

11. Industry or business

Tanning & Leather

MOTHER

FATHER

12. Name

Timothy C. Curley

13. Birthplace

Frostburg, Md.

14. Maiden name

Bridget Donahue

15. Birthplace

Scotland

16. Informant

Mrs. Garrett

Caroline

Address

Main St. Frostburg Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 30-1948
(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg, Md.

18. Funeral director

Jacob Dauber

Frostburg, Md.

Address

Frostburg, Md.

19. (Date rec'd by registrar)

1948

Acting Registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 26 1948 at 10:34

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1948 to June 26 1948

and that I last saw him alive on June 26 1948

Immediate cause of death

Carcinoma of stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

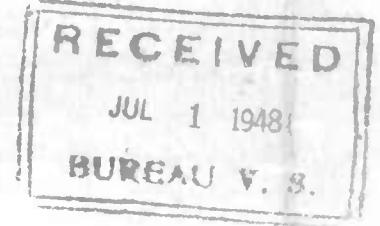
Injured at work?

23. SIGNATURE

John Lane MD

M. D. or other

Address Frostburg, Md. Date signed 6-28-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5723

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

B&O.R.Ry. Power Plant, Virginia Ave.

How long in hospital or institution?

3. (a) FULL NAME

Herman B. Derlan

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife Rose C. Triggleman

6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb. 13-1892

8. AGE:	Years	Months	Days	if less than one day
58	4	1		hrs. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual occupation Engineer, in charge of Power

11. Industry or business Plant at B&O.R.Ry.

12. Name George Derlan

13. Birthplace Vermont

14. Maiden name Theresa Armbruster

15. Birthplace Vermont

16. Informant Walter Derlan

Address 323 Arch St.

17. Burial Date thereof Feb. 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hooper

Address Cumberland, Md.

19. Date rec'd by registrar Feb. 15, 1948

(Date rec'd by registrar) W.H. Baetz, M.D. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Arch St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

about

2D. DATE OF DEATH June 14 1948 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him Dead June 14 1948

Immediate cause of death

Drowning & scalding

DURATION

at once

Due to Accidentally fell in a 20 ft. high tank, 50,000 gallons of water, 170 degrees temperature.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-14-48

Where did injury occur? Cumberland Allegany Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Power Plant B&O.

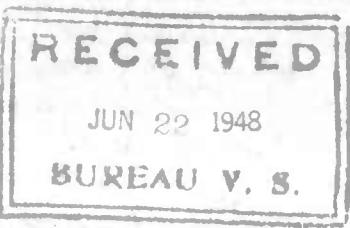
Means of injury Hell in tank of hot water. Injured at work? yes

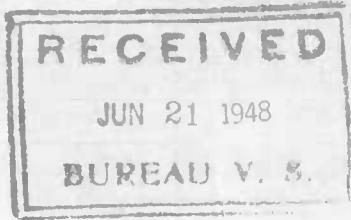
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. number

Address Cumberland Md. Date signed 6-14-48





M PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

9-45-15M

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5725

Reg. Dist. No. 9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Francis Darley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

September 26 1881

8. AGE:

Years
66Months
8Days
6

If less than one day

hrs.

min.

9. Birthplace

Town, county, and state

Pittsburgh, Allegheny, Pa.

10. Usual occupation

Retired

Motor assembler

11. Industry or business

Westinghouse

Electric

12. Name

James

Darley

13. Birthplace

Maryland

Md.

14. Maiden name

Ellen

McHugh

15. Birthplace

Ireland

Ireland

16. Informant

Miss Lillian Feldman

Eckhart, Md.

Address

Burial

Date thereof June 5 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg, Md.

18. Funeral director

J. P. Durst

Address

Frostburg, Md.

19. 6 - 4

19 48 Mrs. Darley & wife

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

169-10-0766

MEDICAL CERTIFICATION

20. DATE OF DEATH

2 June 1948 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 June 1948 to 2 June 1948

and that I last saw him alive on 2 June 1948

Immediate cause of death Coronary

Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

none done

Date of op.

Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

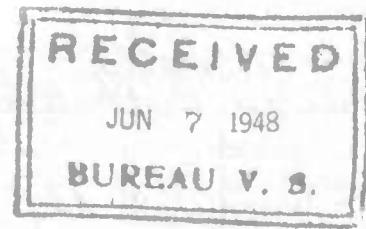
23. SIGNATURE

John B. Davis

M. D. *Dr. Davis*

Address

Frostburg, Md. Date signed 3 June 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5726
942

CERTIFICATE OF DEATH

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany
City or town Westernport Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 77 yrsHospital, institution, or street address where death occurred: 201 Smart St.

How long in hospital or institution?

3. (a) FULL NAME

Oden Bucy Hazenbaker

4. Sex:

5. Color or race:

6. (a) Single, married, widowed, or divorced

Male White married6. (b) Name of husband or wife Ida Hazenbaker6. (c) If alive, give age 97 1/2 years7. Birth date of deceased (mo., day, yr.) March 6 - 18718. AGE: Years 77 Months Days If less than one day hrs. min.9. Birthplace Westernport Md.
(Town, county, and state)10. Usual occupation Paper Mill Worker11. Industry or business Paper Mill12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Fredrick CarrollAddress Hazens Lanes, Md.17. Burial Cemetery Philos Cemetery
(Burial, cremation, or removal, Which?) Date thereof June 7, 1948
(month) (day) (year)Cemetery or crematory Westernport, Md.
Location18. Funeral director Ellewartha & Baal
Address Westernport, Md.19. Date rec'd by registrar June 7, 1948
Signature Allegany Co
Date signed 6-5-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 Smart St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw him dead June 5 1948

Immediate cause of death

Anemia fractureDue to coronary sclerosis

Due to

Other conditions Alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

• PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Deputy Medical Examiner - Allegany Co
Injured at work?23. SIGNATURE: A.V. Denning M.D.M. D. or other Cumberland Address Md. Date signed 6-5-48

RECEIVED

JUN 8 1948

BUREAU V. S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5727

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

Allegany

County

Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

206 Cromwell St.

How long in hospital or institution?

3. (a) FULL NAME

ESSIE RAY FERGUSON

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife William L. Ferguson

6. (c) If alive, give age 63 years

7. Birth date of deceased (mo. day. yr.) February 13, 1887

8. AGE: Years 61 Months 4 Days 5 It less than one day hrs. min.

9. Birthplace Piedmont, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Jacob Hershberger

13. Birthplace Maryland

14. Maiden name Susan Hart

15. Birthplace Piedmont, W. Va.

16. Informant William L. Ferguson

Address Luke, Maryland

17. Burial Date thereof June 21, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory Philos Cemetery

Location Westernport, Md.

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. Date rec'd by registrar June 21, 1948
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Allegany

City or town Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Cromwell St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1948 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March - 1948 to June 18, 1948

and that I last saw her alive on June 18, 1948

Immediate cause of death

acute nephritis

DURATION

3 mo

Due to arteriosclerosis

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Flat Piedmont Ave. Date signed 6/21/48

RECEIVED
JUN 22 1948
BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING
The correct age

I

VSA 15 9-45-15 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5728

93d

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 6 days

3. (a) FULL NAME

John William Frankfort

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Agatha Martin

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

May 8, 1874

8. AGE:

74

Years

1

Months

14

Days

14

If less than one day

hrs.

min.

9. Birthplace

Urzing Pa.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

B.O.T.R. conductor

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mr. Agatha Frankfort

Address 7th, Cumberland, Md.

17. Burial

Date thereof June 25, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hager

Address

Cumberland, Md.

19. Date rec'd by registrar

June 25, 1948

L.W. Davis, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7th, 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

705-09-6097

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 22 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16 1948 to June 22 1948

and that I last saw him alive on June 22 1948

Immediate cause of death

Heart failure

Heart block

Due to Embolus to right brachial

Artery

Due to Aneurysm, Embolism, Arteriosclerosis & Hypertension

Other conditions Heart Disease

Early Gangrene right upper extremity

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. June

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jesse L. Wessman, M.D.

M. D. or other

Address

Cumberland, Md.

Date signed 6/25/48

RECEIVED

JUN 29 1948

BUREAU V. S.

Margin
Contract
agePlease write plainly, with unfading ink. Supply every item of information carefully. The contract
is especially important. Physicians: please write the causes of death clearly and legibly.

DRC. L OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5729

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 1/2 HRS

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 10 1/2 HRS

3. (a) FULL NAME LEE

MASTER DONALD FRIEND

4. Sex MALE Color or race 6. (a) Single, married, widowed, or divorced

MALE W SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 7, 1948

8. AGE: Years 0 Months 1 Days 2 If less than one day hrs. min.

1 MONTH

9. Birthplace # Foothills Maryland
(Town, county and state)

10. Usual occupation none

11. Industry or business

MOTHER FATHER 12. Name ALBERT LEE FRIEND

13. Birthplace MARYLAND

14. Maiden name ALICE MARIE CRONE

15. Birthplace WEST VIRGINIA

16. Informant Albert Lee Friend

Address 202 Spring St. Foothills, Md.

17. Burial Date thereof June 11 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Long Run Cemetery

Location Garrett County, Md.

18. Funeral director Louis Stein, Jr.

Address Cumberland, Md.

19. June 11, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Foothills
(If outside city or town limits, write RURAL and give nearest town)Street No. 202 Spring Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1948 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; then attended deceased from

June 9th 1948 to June 9 1948

and that I last saw him alive on June 9th 1948

Immediate cause of death Post operath Alcock

DURATION 5 hrs

Due to Obstruction

Intestinal Obstruction 30 days

Due to Probably Gangrenous

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

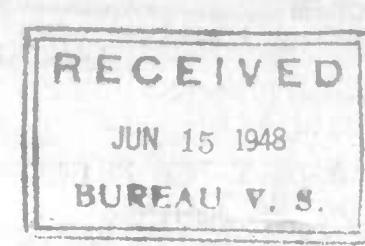
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. R. Owens M.D.

M. D. or other

Address 1000 Mulberry St. Date signed 6-10-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5730

Reg. Dist. No. 8

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

88-7-28

Hospital, Institution, or street address where death occurred:

Douglas Avenue

How long in hospital or institution?

3. (a) FULL NAME

Annie Thompson Fulton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

William Fultons

7. Birth date of deceased (mo., day, yr.)

October 18, 1859

8. AGE:

Years Months Days If less than one day

88 7 28 hrs. min.

9. Birthplace

(Town, county, and state)

Lonaconing Maryland

10. Usual occupation

Housework

11. Industry or business

Our home

12. Name

Adam Thompson

MOTHER FATHER

Scotland

13. Birthplace

Ellen Shears

14. Maiden name

Scotland

15. Birthplace

Scotland

16. Informant

James Chase Fulton

Address

Lonaconing Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof January 3, 1948

(month) (day) (year)

Cemetery or crematory

Oak Hill Cemetery

Location

Lonaconing, Md.

18. Funeral director

J.M. Eichberger

Address

Lonaconing, Md.

19. Date rec'd by registrar

June 12 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Allegany

City or town

Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.

10 Douglas Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

b / 10 1948 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1948 to Jan. 1948, lo.

and that I last saw her alive on Jan. 6, 1948

Immediate cause of death

Congestive Heart Failure

DURATION

Due to Hypertensive C-V disease

2 atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

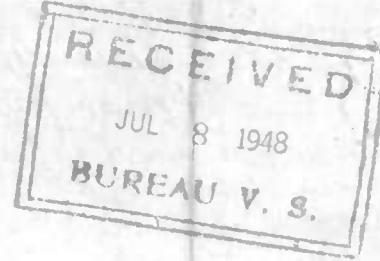
Injured at work?

23. SIGNATURE

Paul Eugene Dry, M.D.

D.O. other

Address Lonaconing, Md. Date Signed June 12, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5731
186a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M
Within corporate limits
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 17 days

3. (a) FULL NAME

Alonzo Ellsworth Gephart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Carrie B. Valentine Gephart

6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.)

Oct. 22- 1878

8. AGE:

Years
69Months
8Days
0

If less than one day

hrs.

min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation retired-Cumberland Steel Co.

11. Industry or business

Harrison Gephart

12. Name

Maryland

13. Birthplace

Lester Zimmerman

14. Maiden name

Maryland

15. Birthplace

Mrs. Carrie B. Gephart.

16. Informant

St. #1 - Latah, Md.

Address

Burial Date thereof June 25, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date signed

Signature

Registrar

Address

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town La Vale, Cumberland, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.E.D.O.L.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1948 10 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. in Dead June 23 1948

Immediate cause of death Epidural hematoma

left middle fossae

DURATION

17
daysDue to a fracture of the skull
left temporal region.

Due to a fall on the street.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-5-48

Where did injury occur? Cumberland Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in front of 157

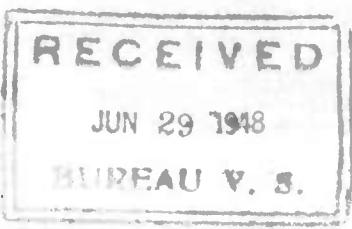
N. Mechanic St. Fall Injured at work? no

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

M. D. or other

Address Cumberland Md. Date signed 6-23-48



Within corporate limits

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5732

830

CERTIFICATE OF DEATH

Reg. Date No. 4

M

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

9 days

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Port Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. Railroad St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Thomas Griffin

3. (b) Social Security Number 705-09-3743

Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Divorced

5. (b) Name of husband or wife Not given

7. Birth date of deceased (mo., day, yr.) March 8, 1882

8. AGE: Years Months Days If less than one day

66 3 4 hrs. min.

9. Birthplace Tyrone Pa.

(Town, county, and state)

10. Usual occupation Railway (Retired)

11. Industry or business

12. Name Emmanuel Griffin

13. Birthplace Pa.

14. Maiden name Mary

15. Birthplace Unknown

16. Informant Besie Griffin

Address Port Savage Md

17. Burial Date thereof June 15 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Chm

Location Port Savage Md

18. Funeral director Louis Stein Ins.

Address Cumberland

19. Date rec'd by registrar June 14 1948 W. H. Dailey M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1948 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to June 12, 1948

and that I last saw him alive on June 12, 1948

Immediate cause of death

Cerebral Hemorrhage
Due to arteriosclerosis and vascular hypertension

Duration 1 week

Several years.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

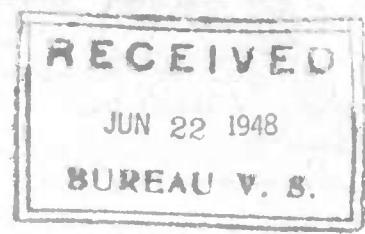
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Morley M.D.

M. D. Date signed June 13 1948

Address Port Savage Md Date signed June 13 1948



Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Inorrect age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5733

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland Md.

How long in hospital or institution? 3 hrs.

3. (a) FULL NAME

Paul Gormer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Harriet Louis Seibert Gormer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 25-1910

8. AGE:

Years

Months

Days

If less than one day

38

4

29

hrs.

min.

9. Birthplace

Cumberland

Md.

(Town, county, and state)

10. Usual occupation

City Fireman

11. Industry or business

MOTHER FATHER

Samuel Gormer

13. Birthplace

Cumberland

Md.

14. Maiden name

Emma M. Heller

15. Birthplace

Md.

16. Informant

Albert Gormer

Address

446 Walnut St

17. Burial

Date thereof June 27, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Rose Hill Cem

Cemetery or crematory

Cumberland, Md.

18. Funeral director

John J. Hafer

Address

Cumberland, Md.

19. Date rec'd by registrar

June 25, 1948 W.L. Faust, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 432 Columbia St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24

19. 48, 12, 30 P.M.

CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him Dead June 24

19. 48

Immediate cause of death Coronary occlusion

due to coronary sclerosis.

DURATION

3 hrs.

Due to

Due to

Other conditions adhesive pericarditis & chronic empyema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

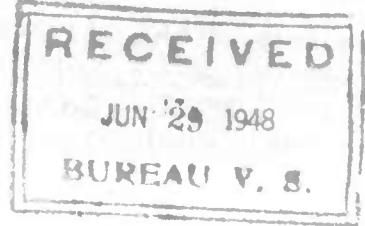
Deputy Medical Examiner Allegany Co

H.V. Deming M.D. H.V. Deming M.D.

M. D. Father

Address Cumberland Md.

Date signed 6-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. W.F.WMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5734

93d

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County **ALLEGANY**City or town **CUMBERLAND, MARYLAND**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? **21 days**

3. (a) FULL NAME

CHARLES W. GROVE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE**WHITE****MARRIED**

6. (b) Name of husband or wife

CORA S. BOWMAN

7. Birth date of deceased (mo., day, yr.)

JANUARY 24, 18846. (c) If alive, give age **58** years

8. AGE:

Years **64**Months **5**Days **6**

If less than one day

hrs. **-**min. **-**9. Birthplace **PENNA.**

(Town, county, and state)

10. Usual occupation **JANITOR**11. Industry or business **CELANESE CORP. OF AMERICA**

MOTHER

12. Name **WESLEY GROVE**

PENNA

13. Birthplace

IDA DEHAVEN

14. Maiden name

MARYLAND

15. Birthplace

16. Informant **MRS. CIRA S. GROVE**Address **POTOMAC PARK RT#6 - Maryland**

17. BURIAL

Date thereof **JULY 3 1948**

(Burial, cremation, or removal. Which?)

Cemetery or crematory **SAHISBURY PA.**Location **SAHISBURY PA.**

18. Funeral director

Address **Stanley M. Thomas**Address **Salisbury Pa**Address **June 30 1948**

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **MARYLAND**County **ALLEGANY**City or town **CUMBERLAND, Maryland**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **RT. #6, POTOMAC PARK,**

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

217-10-5802

MEDICAL CERTIFICATION

20. DATE OF DEATH **JUNE 30, 1948** 19 **2:35 P.M.**

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 1948 19 to **June 30 1948**and that I last saw him alive on **June 30 1948**

Immediate cause of death

Bronic myocardial degenerationDue to **bronic myocardial degeneration**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations **none**Autopsy results **Decedent** Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Wm. J. Williams** M. D. brotherAddress **Cumberland** Date signed **6:30-48**

RECEIVED

JUL 8 1948

BUREAU V. S.

Within corporate limits.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5735

Reg. Dist. No. 4

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County Allegany
City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80-1-10

Hospital, Institution, or Street address where death occurred

535 Fayette St

How long in hospital or institution?

3. (a) FULL NAME

John Hammond4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife B May Shryock

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 18 18688. AGE: Years 80 Months 1 Days 10 If less than one day hrs. min.9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Supt.11. Industry or business Cemetery12. Name Andrew Hammond13. Birthplace Germany14. Maiden name Eva Beckett15. Birthplace Germany16. Informant Mrs May S. HammondAddress Cumberland17. Burial Date thereof July 1 48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. Date rec'd by registrar June 30 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland (If outside city or town limits, write RURAL and give nearest town)Street No. 535 Fayette St (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 28 1948 at 5:45 P.M.

21. CERTIFY that death occurred on the date above stated that I attended deceased from

Jan 1 1948 to June 28 1948 fo. 19and that I last saw him alive on June 28 1948 19

Immediate cause of death

Chronic myocarditis DURATION 7 yrs

Due to

Arterial hypertension DURATION 3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

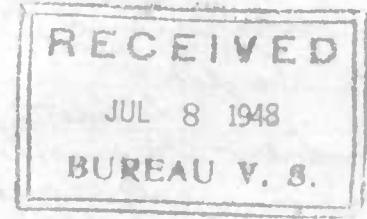
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury Injured at work?

23. SIGNATURE

R.W. Preaskin Jr. M.D. M. D. or otherAddress Cumberland Md. Date signed 6/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

W. J. Lane
5731

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

City or town

Allegany
Frostburg

How long in above place of death?

Hospital, institution, or street address where death occurred:

Bovery St.

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Ann Haverstick

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Graff

Haverstick

7. Birth date of deceased (mo., day, yr.)

June 30, 1865

6. (c) If alive, give age

74 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Vale Summit

Allegany, Md.

(Town, county, and state)

10. Usual occupation

Housewife

Home

11. Industry or business

Anthony Sharpee

12. Name

Anthony

13. Birthplace

Germany

14. Maiden name

Catherine

Tice

15. Birthplace

Germany

16. Informant

William Jones

Frostburg, Md.

Address

Burial

Allegany Cemetery

17. (a) Burial, cremation, or removal. Which?

Date thereof June 17, 1948

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

R. First

18. Funeral director

Frostburg, Md.

Address

19. 6-17 1948 Mrs. Nancy N. Rose

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Allegany

City or town

Frostburg

Bovery St.

Street No.

None

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 14, 1948, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7, 1948, to June 14, 1948,

and that I last saw her alive on June 14, 1948,

Immediately cause of death Coronary heart disease

Due to Hypertension

Due to Heart Block

Other conditions Heart Block

Duration 1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

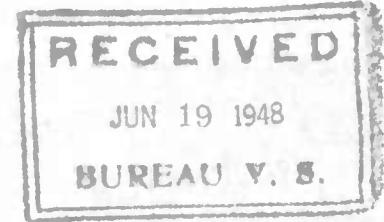
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Frostburg, Md. Date signed 6-13-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. in law
5737
87c
Reg. Dist. No. 9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write MURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miners Hospital
6 weeks

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Hayes

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Female

White

Widowed

6. (b) Name of husband or wife

Charles W. Hayes

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

home

MOTHER FATHER

12. Name

Daniel Lamont

13. Birthplace

Germany

14. Maiden name

Elizabeth Lamont

15. Birthplace

Germany

16. Informant

Walter Hayes

Address

Frostburg, Md.

17. Burial

Date of burial June 10, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

J. R. Durst,

Address

Frostburg, Md.

19. 6-10

1948 Miss Lucy A. Rae

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Allegany

City or town

(If outside city or town limits, write MURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 7 1948 at 8:47 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1946 1948 to June 7 1948

and that I last saw her alive on June 7 1948

Immediate cause of death

arteriosclerosis

DURATION

Several years

Due to

Parkinson syndrome

1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

John Lane MD
Frostburg, Md. Date signed 6-8-48

RECEIVED
JUN 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

5738

CERTIFICATE OF DEATH

Reg. Dist. No.

10

1. PLACE OF DEATH:

County

City or town

Allegany

mt Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

12 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Francis Hergatt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Laura B. Hergatt
deceased

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

March 30, 1858

8. AGE:

Years
90Months
2Days
26If less than one day
hrs. min.

9. Birthplace

mt Savage, Md.

(Town, county and state)

10. Usual occupation

retired machinist

C. & P. shops

11. Industry or business

Harry Hergatt

12. Name

Germany

13. Birthplace

Rachel Lottig

14. Maiden name

Germany

15. Birthplace

mrs Oliver Hergatt

16. Informant

Carrigansville, Md.

Address

Burial

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

Funeral director

Address

Date thereof

(month)

(day)

(year)

Means of injury

Injured at home, farm, industry, public place (where?)

Injured at work?

Date rec'd by registrar

F. Alan G Murray

M. D. or other

Signature

Date signed

Address

Date

Year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Allegany

Carrigansville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

712-18-9343

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 27 1948 at 6:21 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 27 1948 to June 27 1948

and that I last saw him alive on June 27 1948

Immediate cause of death

Exhaustion & Smiling

Due to Fall down 27 evening

left hip

Due to probably fracture

27 & 28 hip

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of May 27 1948

Where did injury occur Carrigansville, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of injury Fall from a wall

Injured at work?

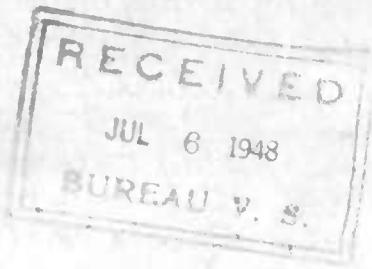
Signature

Date signed

Address

Date

Year



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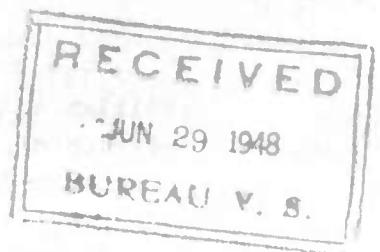
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Within corporate limits
Bring

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5740

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

Allegany
County.....
Cumberland
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

20 Minutes

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

John Dennis Huddle

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife Anne Hammond Huddle

7. Birth date of deceased (mo. day, yr.)

Jan. 11, 1899

6.(c) If alive, give age 42 years

8. AGE:

Years

Months

Days

If less than one day

49

4

29

hrs.

min.

9. Birthplace

Elkton, Va.

(Town, county, and state)

10. Usual occupation

Textile Engineering

11. Industry or business

Celanese Corp. Of America

FATHER

John T. Huddle

MOTHER

Elkton, Va.

13. Maiden name

Sallie Stockdell

15. Birthplace

Gordonsville, Va.

16. Informant

Mrs. Anne Huddle

Address

R.D. # 6 Cumberland, Md.

17. Burial

Date thereof June 13, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

HillCrest Burial Park

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19. June 13, 1948

W.R. Trautz, M.D.
Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. # 6, Bowlegs Green

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-07-6726

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1948, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that deceased from

June 9, 1948, to June 10, 1948

and that I last saw him alive on June 10, 1948

Immediate cause of death

acute coronary occlusion

Due to coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results complete coronary occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

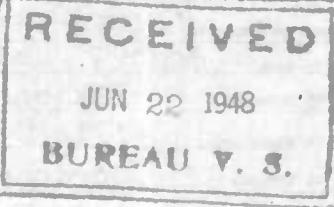
23. SIGNATURE

L. H. Huddles, M.D.

M. D. or other

Address 59 Green

Date signed 6-11-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct edge is especially important. Physicians: please write the causes of death clearly and legibly.



Broadhurst

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

5741

4

Reg. Dist. No.....

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred?

403 Pennsylvania Ave.

How long in hospital or institution?

3. (a) FULL NAME

Mrs Ida Jane Huffman
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles H. Huffman7. Birth date of deceased (mo. day, yr.) June 7, 1871 6. (c) If alive, give age _____ years8. AGE: Years 77 Months 0 Days 13 If less than one day _____ hrs. _____ min.9. Birthplace Yellow Springs 9. Birthplace Preston Co. W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Peter Wolfe 13. Birthplace Preston Co. W. Va.14. Maiden name Louisa Sidwell 15. Birthplace Preston Co. W. Va.16. Informant Mrs Dacie Cox 17. Burial Date thereof June 23, 1948
(Burial, cremation, or removal. Which?)Cemetery or crematory Zion Methodist Cemetery Month June Day 23 Year 1948Location Marquess W. Va18. Funeral director John J. Hager Address Cumberland, Md19. Date rec'd by registrar June 21, 1948 19. Date rec'd by registrar John J. Hager M.D.
(Date rec'd by registrar) Registrar John J. Hager M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va County Preston
 City or town Newburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt 2
(If rural, give LOCATION)

2.(a) If veteran, name war ✓3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19. 48 at 3:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 20 1948 and that I last saw her alive on June 20 1948.

Immediate cause of death

Cerebral Hemorrhage One yearDue to Arteriosclerosis Five yearsDue to Chronic Hypertension Four years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

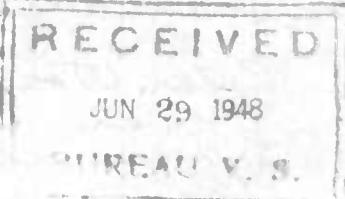
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane o1 injury Injured at work?

23. SIGNATURE J. J. Hager M. D. or otherAddress Cumberland, Md Date signed 6-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5742

CERTIFICATE OF DEATH

159
Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

Spikes Hospital

How long in hospital or institution? 1 day

3. (a) FULL NAME

Baby Boy

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Boy

white

Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 31st, 1948

8. AGE: Years

Months

Days

✓ If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Sherman S. Hyde

13. Birthplace Frostburg, Md.

14. Maiden name Ruby Shires

15. Birthplace Frostburg, Md.

16. Informant

Mr. Carson F. Hyde

Address Frostburg, Md.

17. Burial

Date thereof 6-3-1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill

Location

Morgan, Md.

18. Funeral director

Jackie Baker

Address

Frostburg, Md.

19. 6-5

19-48 Mrs. Harry X. Roe

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Allegany

City or town Barton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(o) If veteran, name war

3. (b) Social Security Number

Hyde

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1948 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31 1948 to June 2 1948

and that I last saw him alive on June 2 1948

Immediate cause of death

Prematurity

DURATION

7 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

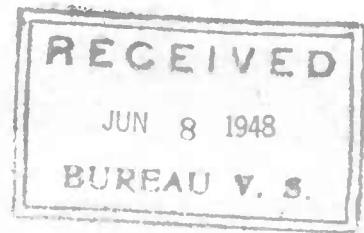
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Edmundson w/ 6/3/48 Date signed



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5743
1318

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important.

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital
one day

How long in hospital or institution?

3. (a) FULL NAME

Antoinette Indolfi

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

Salvatore Indolfi

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) March 11 1895

8. AGE: Years 53 Months 3 Days 0 If less than one day hrs. min.

9. Birthplace Naples Italy
(Town, county, and state)

10. Usual occupation Housewife at home

11. Industry or business

12. Name Angelo Albino

13. Birthplace Italy

14. Maiden name Josephine Russo

15. Birthplace Italy

16. Informant Dominick Indolfi

Address 913 Frederick St. Cumberland, Md

17. Burial Date thereof 1-1-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter's & Paul's Cemetery

Location Cumberland Md

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. June 13, 1948 (Date rec'd by registrar)

W. Frank M. D. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 913 Frederick St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1948 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 to July 11 1948

and that I last saw her alive on July 10 1948

Immediate cause of death Myocarditis

Duration 4 yrs

Due to:

Due to:

Other conditions Chronic hepatitis 4 yrs
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

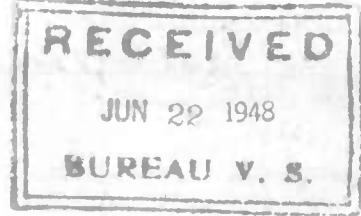
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James T. Johnson, M.D. or other

Address 21 Park St. Cumberland, Md. Date signed 6-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5744

Reg. Dist. No... 8

CERTIFICATE OF DEATH

93a

1. PLACE OF DEATH:
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Allegany
City or town..... Pekin
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME
Henry Johnson

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Male	White	Married	
6. (b) Name of husband or wife <i>Laura Hammon Johnson</i>			
7. Birth date of deceased (mo., day, yr.)	6. (c) If alive, give age 60 years		
8. AGE: Years 70	Months 3	Days 15	If less than one day hrs. min.
9. Birthplace <i>Livingston Allegany Co., Md.</i> (Town, county, and state)			
10. Usual occupation <i>Retired coal Miner</i>			
11. Industry or business <i>Campbell Coal Mine</i>			
MOTHER FATHER	12. Name <i>Johnson</i>		
	13. Birthplace <i>unknown</i>		
	14. Maiden name <i>Spiker</i>		
	15. Birthplace <i>Scotland</i>		
	16. Informant <i>William Johnson</i>		
	Address <i>Pekin, Md.</i>		
	17. Burial (Burial, cremation, or removal. Which?) <i>Burial</i>	Date thereof <i>June 25 1948</i>	(month) (day) (year)
	Cemetery or crematory <i>Garrison Hill Cemetery</i>		
	Location <i>Pekin, Md.</i>		
	18. Funeral director <i>W. E. Johnson</i>		
	Address <i>Concordia Md</i>		
	19. June 25 1948 (Date rec'd by registrar)	Jannette M. Bal Registrar	

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 22 1948*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 21 1948* to *June 22 1948* and that I last saw him ~~alive~~ *alive* on *June 22 1948*

Immediate cause of death
acute myocarditis

DURATION
3 wks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

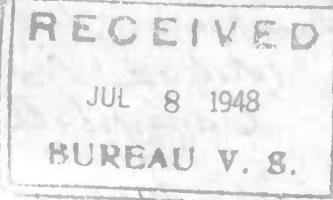
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Perry Jr. D.*

M. D. or other

Address *Piedmont Co. Ga* Date signed *6/24/48*



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5745

Reg. Dist. No. 9

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County

City or town

Allegany

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter C. Kennedy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

married

6. (b) Name of husband or wife

Anna Kennedy

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 2 - 1882

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

65

7

18

9. Birthplace

(Town, County, and state)

Frederick - allegy md

city laborer

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name

Buckhead Kennedy

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

RECEIVED

JUN 23 1948

BUREAU V. S.

M PLEASE WRITE PLAINLY, WITH **BLACK** INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5746

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County..... Allegany

City or town..... Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 35 years

Hospital, institution, or street address where death occurred:..... 313 Hammond St.

How long in hospital or institution?..... - - - - -

3. (a) FULL NAME

ETTA VIRGINIA KERN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife..... Emmanuel M. Kern

7. Birth date of deceased (mo., day, yr.)..... May 11, 1870

6. (c) If alive, give age..... 85 years

8. AGE: Years	Months	Days	If less than one day
78	1	11	hrs. min.

9. Birthplace..... Bedford, Bedford, Penna.
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business..... Own home

12. Name..... Henry C. Lashly

13. Birthplace..... Penna

14. Maiden name..... Not known

15. Birthplace.....

16. Informant..... Ma E. M. Kern

Address..... 313 Hammond St, Westernport, Md.

17. Burial..... Date thereof..... June 20, 1948
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Philo's Cemetery

Location..... Westernport, Maryland

18. Funeral director..... Ellsworth S. Boal

Address..... Westernport, Maryland

19. Date rec'd by registrar..... June 26, 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Westernport
(If outside city or town limits, write RURAL and give nearest town)Street No..... 313 Hammond St.
(If rural, give LOCATION)

2.(a) If veteran, name war..... - - - - -

3. (b) Social Security Number

MEDICAL CERTIFICATION

June 20 (23) 1948 at 4:00 a.m.

20. DATE OF DEATH..... June 1, 1948, to June 22, 1948
and that I last saw h..... alive on..... 1948Immediate cause of death..... Carcinoma of breast
with metastasis to lung. DURATION..... 142

Due to.....

Due to.....

Other conditions..... Bronchopneumonia (terminal) 1 day

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Norman Reesee, M.D.

M. D. or other

Address..... Westernport, Md. Date signed..... 6/23/48

RECEIVED
JUN 28 1948
BUREAU V. S.

Within corporate limits WILSON

5747

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 FRANKLIN ST.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

MR. JOHN F. KERNS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife HETTIE MORELAND

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) APRIL 16, 1870

8. AGE: Years 78 Months 2 Days 4 If less than one day hrs. min.

9. Birthplace WEST VIRGINIA
(Town, county, and state)

10. Usual occupation RETIRED B & O EMPLOYEE

11. Industry or business

MOTHER FATHER FREDERICK KERNS

13. Birthplace VIRGINIA

14. Maiden name HARTLEY, ELIZABETH
MARYLAND

16. Informant MEMORIAL HOSPITAL
MEMORIAL AVE., CITY

17. Burial Date thereof June 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Cemetery

Location Laurel, Md.

18. Funeral director W. H. Wilson

Address Augusta W.Va.

19. Date June 21, 1948 (Date rec'd by registrar) Walter R. Gray, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20, 1948 at 3:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 1948 to June 20, 1948

and that I last saw him alive on June 19, 1948

Immediate cause of death

Haemoptysis

artitis sclerica

Due to

Thy. Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. M. Wilson, M.D. or other

Date signed 6-20-48

RECEIVED

JUN 29 1948

FBI - BUREAU
RECEIVED

JUN 29 1948

FBI - BUREAU
RECEIVED

DR. RANSON
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5748

159
Reg. Dist. No. 4

CERTIFICATE OF DEATH

C 1. PLACE OF DEATH:

County... allegany.....

City or town... CUMBERLAND.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL.....

How long in hospital or institution? 22 HRS.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND.....

County... Garrett.....

City or town... CUMBERLAND.....

(If outside city or town limits, write RURAL and give nearest town)

Street No... DEER PARK MD.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

KIMMELL BABY GIRL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE WHITE

NEW BORN

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

JUNE 28, 1948

8. AGE: Years

Months

Days

If less than one day

22 hrs. min.

9. Birthplace... CUMBERLAND ALLEGANY MD

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER 12. Name... RUSSELL KIMMELL

13. Birthplace MARYLAND

14. Maiden name VIOLA BROADWATER

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE

17. Cremation Date thereof... June 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hospital

Location CUMBERLAND, Maryland

18. Funeral director As above

Address

19. June 29, 1948
(Date rec'd by registrar)

Lub. Frank, M.D.
Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 29 1948 at 3:00 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

28 June 1948 to 29 June 1948

and that I last saw her alive on 9 PM 28 June 1948

Immediate cause of death Respiratory failure DURATION

Prematurity

Due to: 6/30/48

Due to: 6/30/48

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

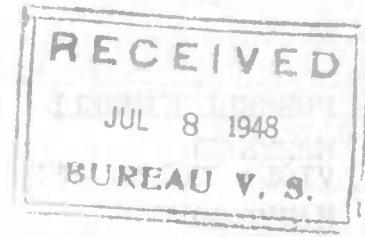
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE DR. RANSON M.D. or other

Address 91 Greene St. Cumberland, Maryland Date signed 29 June 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5749

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH
INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miner Hospital

How long in hospital or institution?

1 day

3. (a) FULL NAME

Linnie B. Kirby

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

married

6. (b) Name of husband or wife

Joseph P. Kirby

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.)

Mar 28 - 1880

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Mt. Savage - Alleg - Md.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

MOTHER FATHER

12. Name

Joshua Leasone

13. Birthplace

Bedford Valley, Pa.

14. Maiden name

Mary Elizabeth Rose

15. Birthplace

Cumberland, Md.

16. Informant

Roy Kirby

Address

Frostburg, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Jan 3-1948
(month) (day) (year)

Cemetery or crematory

C.M.B. Cemetery

Location

Mt. Savage, Md.

18. Funeral director

Joseph R. Quist

Address

Frostburg, Md.

19. 6-12

(Date rec'd by registrar)

1948 Mrs. Nancy K. Rae

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

allegany

City or town

Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1948 at 7 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2 1948 to June 10 1948

and that I last saw her alive on June 10 1948

Immediate cause of death

apoplectic coma

convulsions

DURATION

1 day

Due to

hypertension

Due to

chronic nephritis

Other conditions

diabetes

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

A. Wolferman M.D.

M. D. or other

Address 134 E Main & Frostburg Date signed 6-12-48

RECEIVED

JUN 14 1948

BUREAU V. S.

WILLIA DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

5750

4

Reg. Dia. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

3. (a) FULL NAME

BABY BOY KNISLEY, Robert James

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 25, 1948

8. AGE: Years Months Days If less than one day

1 DAY 0 0 1 hrs. min.

9. Birthplace CUMBERLAND, ALLEGANY, MD. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name ROBERT KNISLEY

13. Birthplace W. VA.

14. Maiden name ESTHER G. HOUSE

15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof JUNE 28, 1948

(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hooper

Address Cumberland, Md.

19. (Date rec'd by registrar) June 28, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.

County

ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 233 VIRGINIA AVE.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 26

19 48 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on June 26, 1948.

Immediate cause of death

Premature birth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

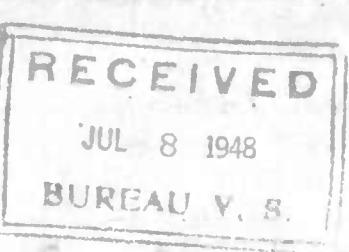
Means of injury

Injured at work?

23. SIGNATURE

John clayton Burris
Cumberland, Md. 27714
or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

HUM No. G 116 JUL 8 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5751

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: 49 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Spouse of

7. Birth date of deceased (mo., day, yr.)

April 29th 1888

(c) If alive, give age years

58

8. AGE: Years Months Days If less than one day

59 1 27 hrs. min.

9. Birthplace: Castle, Allegany, Md.

(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal mines

12. Name: George Lashbaugh

13. Birthplace: Boston, Md.

14. Maiden name: Elizabeth Paley

15. Birthplace: Garrett Co., Md.

16. Informant: Mrs. Frank Dager

Address: Box 195 Frostburg, Md.

17. Burial: Allegany

(Burial, cremation, or removal. Which?)

Date thereof: June 28 1948
(month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: Dean of People

Address: Frostburg, Md.

19. (Date rec'd by registrar) 6/29 1948
20. Registrar: Mr. R. E. Rice

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md.

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. No. 2

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

213-07-9874

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-25

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 27 1948 to June 25 1948

and that I last saw him alive on June 25 1948

Immediate cause of death: Hemoptysis

paroxysmal hypertension

DURATION

1 day

Due to: pulmonary tuberculosis

chronic nephritis

Due to:

Other conditions: Silicosis

2

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

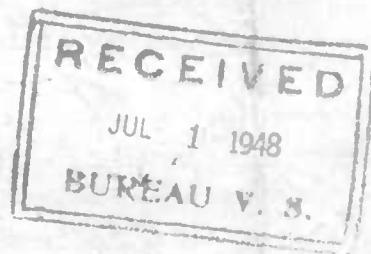
Injured at work?

23. SIGNATURE: S. Wolfman N.O.

M. D. or other

Address: Frostburg

Date signed: 6-26-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5752

1600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

Harold N. E. Baby Lensure

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 21 1948

8. AGE: Years Months Days If less than one day

1 hrs. 30 min.

9. Birthplace

Cumberland Md.

(Town, county, and state)

10. Usual occupation.

11. Industry or business

None

MOTHER FATHER

12. Name... None Daniel Lensure

13. Birthplace Oldtown Md.

14. Maiden name Engenia Steckman

15. Birthplace Oldtown Md.

16. Informant None al Lensure

Address Oldtown Md.

17. Burial Date thereof 6-21-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oldtowm Cem

Location Oldtown Md.

18. Funeral director Louis Stein Inc

Address Cumberland

19. June 21 1948 W. D. Frank, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State... Maryland County... Allegany

City or town... Oldtown (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 21 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 21 1948 to June 21 1948

and that I last saw him alive on June 21 1948

Immediate cause of death intramural hemorrhage

DURATION 1 hour

Due to:

birth injury

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

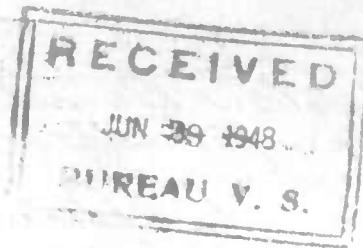
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John H. King, M.D. M. D. or other

Address 59 Greene St. Date signed 6-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible entries are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

5753

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... **ALLEGANY**
 City or town..... **CUMBERLAND, MARYLAND**
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HospitalHow long in hospital or Institution? **9 HRS.**

3. (a) FULL NAME

ELLSWORTH LEWIS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE**WHITE****Widowed**

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age..... years

October 17, 1871

8. AGE:

76**8****12****hrs.****min.**

9. Birthplace

W. V.A.

(Town, county, and state)

10. Usual occupation

Trackman - Retired

11. Industry or business

B. & O. R.R. Co.

MOTHER FATHER

12. Name

Samuel Lewis

13. Birthplace

Cumberland, W. Va.

14. Maiden name

Unknown

15. Birthplace

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17. Burial or cremation

Date thereof

June 29 '48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Pine Grove

Location

Near Terra Alta, W. Va.

18. Funeral director

Fisher-Watson Fun Home

Address

Terra Alta, W. Va.

19. Date rec'd by registrar

June 29**1948****Web. Tracy, M.D.****Registrar**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **WEST V.A.**

County.....

PrestonCity or town..... **TERRA ALTA**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **RT. #8**

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

JUNE 29, 1948, 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6.29. 1948 6.29. 1948and that I last saw him alive on **6.29. 1948**

Immediate cause of death

Chronic hepatitis (cirrhotic).

Due to

Chronic myocardial degeneration

Due to

Degeneration

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

NoneDate of op. **None**

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

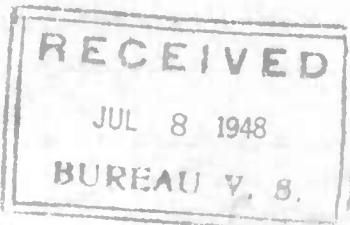
Means of injury Injured at work?

23. SIGNATURE

W.F. Williams

M. D. or other

Address..... **Cumberland** Date signed **6.29.48**



With the appropriate initials

Initials are
to be written here

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5754

Reg. Dist. No. 4

CERTIFICATE OF DEATH

92c

1. PLACE OF DEATH:
County. Allegany

City or town. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs.

Hospital, institution, or street address where death occurred:
124 N. Center St.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Ethel B. Frantz Gunning Liles

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white	widow

6. (b) Name of husband or wife	Charles V. Liles
--------------------------------	------------------

7. Birth date of deceased (mo. day yr.)	6. (c) If alive, give age years
May 10 1886	

8. AGE: Years	Months	Days	11 less than one day
62	1	17	hrs. min.

9. Birthplace	Cumberland Md. (Town, county, and state)
---------------	---

10. Usual occupation	House wife
----------------------	------------

11. Industry or business	Home
--------------------------	------

12. Name	Daniel Frantz
----------	---------------

13. Birthplace	England
----------------	---------

14. Maiden name	Flavilla Bowden
-----------------	-----------------

15. Birthplace	Unknown
----------------	---------

16. Informant	Mr. Eugene Gunning
Address	Cumberland, Md.

Burial	Date thereof June 30 1948
--------	---------------------------

17. (Burial, cremation, or removal. Which?) Cemetery or crematory	(month) (day) (year) Rose Hill Cem.
---	--

Location	Cumberland, Md.
----------	-----------------

18. Funeral director	Louis Stein Inc.
Address	Cumberland, Md.

19. (Date rec'd by registrar)	June 30 1948 W. B. Frantz, M.D. Registrar
-------------------------------	---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. Md. County. Allegany

City or town. Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 124 N. Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1948 about 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19...
and that I last saw her dead June 29 1948

Immediate cause of death

Chronic (rheumatic) endocarditis

?

DURATION

several years

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

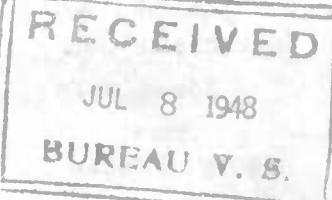
Means of injury

Injured at work?
Deputy Medical Examiner = Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 6-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The corollary is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
limits is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5755

94a

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Alleghany
Near Cumberland, Rural

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

Came to Dr. Murray's home, Little Md.
(Proclaimed dead there)

How long in hospital or institution?

(If outside city or town limits, write RURAL and give nearest town)

3. (a) FULL NAME

Lawrence Mathias

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Violet Kirschner

7. Birth date of deceased (mo., day, yr.)

Sep 5, 1903

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

44 9 6 hrs. min.

9. Birthplace..... Corriganville, Alleghany Mds.

(Town, county, and state)

10. Usual occupation..... Tire Worker

11. Industry or business..... Rubber Mfg.

12. Name..... William L. Logsdon

13. Birthplace..... Alleghany Co., Mds.

14. Maiden name..... Martha Everline

15. Birthplace..... Somerset Co., Penna.

16. Informant..... Violet Logsdon

Address..... Corriganville, Md.

Burial

Date thereof..... June 14, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Wellersburg Ref. Church

Location..... Wellersburg, Penna.

18. Funeral director..... Harvey H. Zeigler

Address..... Hyndman, Pa.

19. Date rec'd by registrar..... June 14, 1948

W.H. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Alleghany

City or town..... Corriganville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-015-479

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 11, 1948 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1948, to June 11, 1948
and that I last saw him alive on June 11, 1948

Immediate cause of death.....

Coronary Thrombosis

DURATION

4 hrs

Due to..... Cardiac due to blood
vessel burst in auto accident

Due to..... May 28-48 2 wks

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

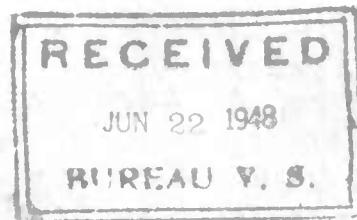
Means of injury.....

Injured at work?

23. SIGNATURE.....

F. Alan G. Murray, M.D.
Cumberland, Md. Date signed June 11
M. D. or other 48
Address.....

Molar v. trans. recd. from Com. M.V. - Dr. Maldeus advised that
the auto. acc. could not have caused the coronary
Thrombosis. 8/9/48 A.S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5756

115c
Reg. Dist. No. 9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Allegany
Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution?

4 hours

3. (a) FULL NAME

George Joseph Mallow

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

May 4, 1943

8. AGE: Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state) Frostburg, Allegany, Md.

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name..... Guy Mallow

13. Birthplace West Virginia

14. Maiden name Ruth Lancaster

15. Birthplace Maryland

16. Informant Guy Mallow

Address

17. Burial Date thereof June 26, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

18. Location Frostburg, Md.

19. Funeral director

Address

20. Date rec'd by registrar

1948

(Date rec'd by registrar)

H. B. O'Brien
Veterin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Frostburg

Street No. 68 Hill St

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/23

19

48

at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/20

1947 to

6/23

1948

and that I last saw him alive on

6/23

1948

Immediate cause of death

Respiratory paralysis

DURATION

10 min.

Due to Ether anesthesia for tonsillectomy (35 min p. operation).

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Chronic hypertrophied infected tonsils + adenoids Date of op. 6/23/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

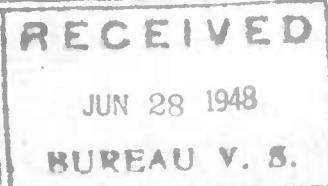
23. SIGNATURE

Frank T. Harrel M.D.

M. D. or other

Address 59 E. Main St, Frostburg, Md.

Date signed 6/25/48



DR HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5757

160C

Reg. Dist. No. 4

CERTIFICATE OF DEATH

M
CPLACE OF DEATH:
ALLEGANY

County

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 HRS 45 MINUTES

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 5 HRS 45 MI

3. (a) FULL NAME

(McElfish)

BBBY BOY McELEISH

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

JUNE 5, 1948

8. AGE:

Years

Months

Days

If less than one day

5 hrs. 45 min.

9. Birthplace CUMBERLAND, ALLEGANY, MARYLAND
(town, county, and state)

10. Usual occupation

11. Industry or business

12. Name WILLIAM McELEISH

13. Birthplace CUMBERLAND, MARYLAND

14. Maiden name JOAN MARY KERR

15. Birthplace NEW YORK CITY, NEW YORK

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL AVE

17. BURIAL Date thereof JUNE 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HILLCREST CEMETERY

Location CUMBERLAND, MARYLAND

18. Funeral director JOHN J. HAFFER

Address CUMBERLAND, MARYLAND

19. June 1, 1948 W. Frank, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 618 NIAGRA ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 5 1948 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

June 5 1948 to June 5 1948
and that I last saw him alive on June 5 1948

Immediate cause of death Pneumonia

Duration

Separated Placenta

Due to

Other conditions Compound presentation

- Vertex, right hand & foot.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results O
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

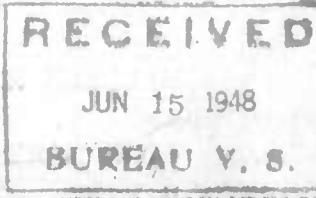
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W.H. Hodges, M.D.
M. D. or other

Address Cumberland, Md. Date signed 6/5/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

5758

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

allegany
Cumberland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

allegany Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of hair

6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

hrs. 19 min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name James E. Mittenberger

13. Birthplace Md

14. Maiden name Mary A. Replawn

15. Birthplace Md

16. Informant James E. Mittenberger

Address 1 Ridgeley Rd. Va.

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof 6/26/48

(month) (day) (year)

Cemetery or crematory St Peter & Paul Cem.

Location Cumberland

18. Funeral director

Address Allegany Funer Inc

19. June 26, 1948

(Date rec'd by registrar)

W.H. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Ridgeley rural

Street No. Pt. of. 1/2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25 1948 to June 25 1948

and that I last saw him alive on June 25 1948

Immediate cause of death

Premature birth

Liver c

Due to delayed delivery

Asphyxia

Due to pressure on lungs

Delayed delivery

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

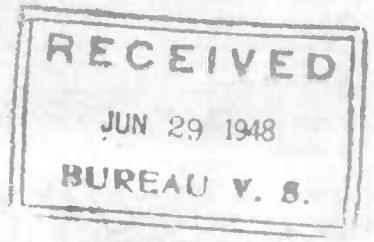
23. SIGNATURE

F. Allen G. Kennedy, M.D.

M. D. or other

Address Cumberland

Date signed June 25 1948



Louis Bringy

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5759

830

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 8 weeks

3. (a) FULL NAME

Walter Daniel Mart

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary C. Mansfield

7. Birth date of deceased (mo., day, yr.)

September 10, 1892

6.(c) If alive, give age

51

years

8. AGE:

Years
55Months
8Days
25

It less than one day

hrs.

min.

B. Birthplace

Mt. Savage Allegany, Maryland

(Town, county, and state)

10. Usual occupation

Pipe Shop Foreman

11. Industry or business

Kelly Springfield Tire Co.

MOTHER FATHER

Charles Walter Mart

13. Birthplace

Halifax, Nova Scotia.

14. Maiden name

Louisa Darnell

15. Birthplace

Carlisle, England

16. Informant

Mrs. Mary C. Mart

Address

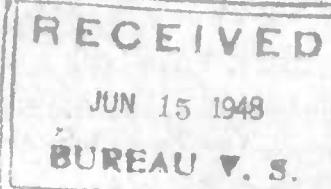
210½ Knox St. Cumberland, Md.

17. Burial

Date thereof June 8, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)



Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

5760

4

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

70 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

21 Days

3. (a) FULL NAME

Alfred Northcraft

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife

Clara Northcraft

7. Birth date of deceased (mo., day, yr.)

September 22 1873

6.(c) If alive, give age years

8. AGE: Years

74

Months

9

Days

4

If less than one day

hrs.

min.

9. Birthplace

Green Ridge, Md. Allegany Co

(Town, county, and state)

Guard

10. Usual occupation

11. Industry or business

Kelly Springfield Tire Co

Edward Northcraft

MOTHER FATHER

12. Name

Green Ridge, Md.

13. Birthplace

Mary Roby

14. Maiden name

Green Ridge, Md.

15. Birthplace

Micheal Northcraft

16. Informant

Beryl, W. Va.

Address

17. Burial

Date thereof 6/28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Rose Hill Cemetery

Cemetery or crematory

Cumberland, Md.

Location

William H. Kight

18. Funeral director

Cumberland, Md.

Address

19. June 28, 1948

(Date rec'd by registrar)

W.H. Frank, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 88 LaVale Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-07-0770

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/26

19 48 21

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/5

19 48

6/26

19 48

and that I last saw him alive on 6/25

19 48

6/26

19 48

Immediate cause of death

straphal embolism

DURATION

5 days

Due to

coronary occlusion

20 days

Due to

arteriosclerotic heart disease

10 days

Other conditions

arteriosclerosis

5 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

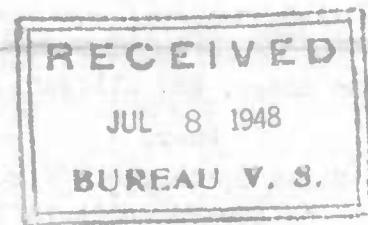
Injured at work?

23. SIGNATURE

M. D. or other

Address LaVale, Md. Date signed 6/26

L. Bruegel



Within corporate limits.

M PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5761

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3.1 years

Hospital, Institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution? 6 weeks

3. (a) FULL NAME

Mrs. Estella Pennington

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Phillip Pennington

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 21, 1881

8. AGE:

Years 67

Months 1

Days 9

If less than one day hrs. min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name James H. Hellyer

13. Birthplace South Hampton, England

14. Maiden name Mary E. Hetz

15. Birthplace Baltimore, Md.

16. Informant

Mr. L. L. Free
Address 616 Sylvan Ave., Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?) Cemetery or crematory

Date thereof July 3, 1948
(month) (day) (year)

Baltimore Cemetery

Location Baltimore, Maryland

18. Funeral director

John J. Hayes
Address Cumberland, Md.

19. Date rec'd by registrar

July 1, 1948 W. K. Branty M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 616 Sylvan Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1948, at 10⁵⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 23, 1948, to June 30, 1948,

and that I last saw her alive on June 29, 1948.

Immediate cause of death

Myocardial failure

Due to Atherosclerotic hypertension disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

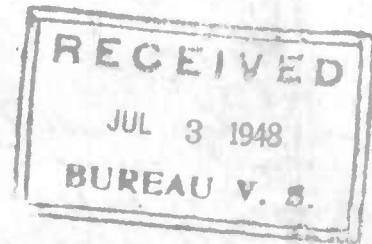
Injured at work?

23. SIGNATURE

Arthur F. Jones, M.D.

M. D. or other

Address 110 S. Centre St. Date signed July 1, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5762

8

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH:

County..... Allegany

City or town..... Lonaconing Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Douglas Ave.

How long in hospital or Institution?

3. (a) FULL NAME

Elizabeth Ann Plashett

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 8 - 1878

8. AGE: Years

Months

Days

If less than one day

69 8 21

hrs.

min.

9. Birthplace.....

Pekin, Allegany Co, Md.

(Town, County, and State)

10. Usual occupation.....

Housework

11. Industry or business.....

Own home

MOTHER FATHER

12. Name..... William Plashett

13. Birthplace..... England

14. Maiden name..... Elizabeth Black

15. Birthplace..... England

16. Informant..... Mrs. George P. Murdoch

Londcaring, Md.

Address.....

17. Burial..... Date thereof..... July 1, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Laurel Hill Cemetery

Location..... Monocor, Md.

18. Funeral director..... M. Eichhorn

Address..... Lonaconing, Md.

19. Date rec'd by registrar..... July 10, 1948

Signature..... Jannettine Coal

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Allegany

City or town..... Pekin

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Douglas Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 29

19. 48, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw her..... Dead..... June 29

19..... 48.

Immediate cause of death.....

Coronary occlusion due to
Coronary sclerosis

DURATION

at once

Due to.....

Due to.....

Other conditions..... Epileptic for 55 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE..... H. V. Deming M.D. H. V. Deming M.D.

M. D. or Dr.

6-29-48

Address..... Cumberland Md. Date signed.....

RECEIVED

JUL 8 1948

BUREAU V. S.

1600

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

ALLEGANY

City or town

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 HRS 28 MI

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

7 HRS 28 MI

3. (a) FULL NAME

PRICE BABY GIRL DONNA SUE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

NEWBORN

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

JUNE 28, 1948

8. AGE:

Years

Months

Days

If less than one day

7 hrs. 28 min.

9. Birthplace

Cumberland Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name JOHN PRICE

13. Birthplace MARYALND, Cumberland

14. Maiden name NORMA JEAN Mc CALL

15. Birthplace MARYALND, Cumberland

16. Informant MEMORIAL HOSPITAL

Address

MEMORIAL AVE.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 6/30/48

(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

June 30, 1948 W.H. Kight, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 476 BALTO. AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

JUNE 29, 1948, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

28 June 1948, to 29 June 1948

and that I last saw her alive on 29 June 1948

Immediate cause of death

Prematurity (7 mo.)

Due to Premature Separation
placenta

Due to

Other conditions

Prematurity -

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Deller B. Whitworth M. D. or other

Address 112 Bedford St.

Date signed 29 Jun 1948

RECEIVED
JUL 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

5764

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 3 weeks

3. (a) FULL NAME

Wm. S. Bairick4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Wm. Schneider6. (c) If alive, give age 56 years

7. Birth date of deceased (mo. day, yr.)

May 13 - 18898. AGE: Years 59 Months 0 Days 23 If less than one day hrs. min.9. Birthplace Frostburg, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Farm Work Operator

11. Industry or business

12. Name Joseph S. Bairick13. Birthplace Allegany Co., Md.14. Maiden name Celia M. Smith15. Birthplace Frostburg, Md.16. Informant Mrs. Elizabeth SquatinoAddress Consolidation Frostburg, Md.17. Burial Burial Date thereof 6-8-48
(Burial, cremation, or removal. When?)Cemetery or crematory St. Michael's CemeteryLocation St. Frostburg, Md.18. Funeral director Jacob SpikerAddress Frostburg, Md.19. Date rec'd by registrar June 7, 1948 Registrar J.W. Daub M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Consolidation, Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

213-18-0935

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 47 1948 to June 5 1948and that I last saw h. 5 alive on June 4 1948

Immediate cause of death

peritonitisDue to appendicitis (ruptured)

Due to

Other conditions intestinal obstruction
and multiple abdominal abscesses

(Include pregnancy within 3 months of death)

Major findings of operations ruptured gallbladder
appendicitis, peritonitis Date of op. 5-13-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE (Witness M.D.)

M. D. or other

Address 59 Green St. Date signed 6-5-48

RECEIVED
JUN 15 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr P. R. Wilson

5765

6

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Allegany

City or town..... Westernport - rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 66 years

Hospital, institution, or street address where death occurred:

1 mile north of Westernport

How long in hospital or institution?.....

3. (a) FULL NAME

WALTER EDWARD RANDALLS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

May 7, 1882

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

66

1

0

9. Birthplace.....

Franklin, Allegany, Maryland
(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

Pulp mill

MOTHER FATHER

12. Name.....

David Randalls

13. Birthplace

West Virginia

14. Maiden name.....

Rebecca Carver

15. Birthplace

Virginia

16. Informant.....

Mrs Pansy Blackburn

Address

Westernport, Md.

17. Burial.....

Date thereof..... June 10, 1948
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory..... Philo's Cemetery

Location.....

Westernport, Md.

18. Funeral director.....

Ellsworth S. Boal

Address

Westernport, Maryland

19. Date rec'd by registrar

19

48

May

10

1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Westernport - rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1 mile north of Westernport

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-18-1389

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 7, 1948 19..... at 10:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4, 1948, to June 7, 1948,

and that I last saw him alive on June 7, 1948.

Immediate cause of death Chronic Myocarditis
and Myocardial Degeneration
not specified as Pathologic
Duration 1 Year

Due to.....

Due to.....

Other conditions..... Pulmonary Edema 1 Day

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

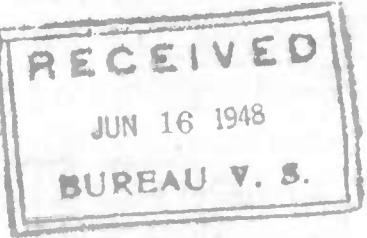
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Paul R. Wilson, M.D.

A. D. or other

Address..... Piedmont W.Va. Date signed June 9, 1948



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5767

Reg. Dist. No.

4

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

68-10-16

Hospital, institution, or street address where death occurred:

Allegany Hospital

5 days

How long in hospital or institution

3. (a) FULL NAME

John S. Reed

4. Sex

5. Color of hair

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mary O' Walsh

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

July 26 1879

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Cumberland Md

(Town, county, and state)

10. Usual occupation

Baker's Restaurant

11. Industry or business

Proprietor

MOTHER FATHER

12. Name

James Reed

Md

13. Birthplace

England

14. Maiden name

Elizabeth Blundering

15. Birthplace

England

16. Informant

Mrs. Mary S. Reed

Address

Cumberland

17. Burial

Date thereof June 15 1848

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Mary's Burial Park

Location

New Cumberland Md

18. Funeral director

Loris Stein Inc

Address

Cumberland

19. Date rec'd by Registrar

June 14 1948

(Date rec'd by Registrar)

W.H. Frantz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 500 Hilltop Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-05-6466

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 12 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6 1948 to June 12 1948
and that I last saw him/her alive on June 12 1948

Immediate cause of death

acute pulmonary
congestion -
chronic myocarditis
3 days

Due to

Due to

Other conditions

Hypertension
obesity
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

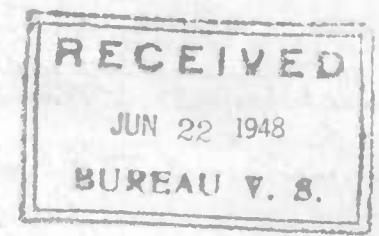
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Reed Jr. M.D.
Address 49 Green St. Date signed June 14 1948
M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr Wolverton 5768

2411 N. Charles St., Baltimore

484

6

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Allegany

City or town.....

Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

24 days

Hospital, Institution, or street address where death occurred:

99 Mullen Ave.

How long in hospital or institution? - - - - -

3. (a) FULL NAME

ANNA ANITA REEVES

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife.....

James A. Reeves

7. Birth date of deceased (mo., day, yr.)

December 25, 1898

6. (c) If alive, give age 61 years

8. AGE: Years

Months

Days

If less than one day

49

5

15

9. Birthplace.....

France

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business

Own home

MOTHER FATHER

12. Name.....Nanis Ecthesches

13. Birthplace France

14. Maiden name May Harmbalage

15. Birthplace France

16. Informant James A. Reeves

Address Luke, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 13, 1948

(month) (day) (year)

Cemetery or crematory

Philos Cemetery

Location

Westernport, Maryland

18. Funeral director

Ellsworth S. Boal

Address

Westernport, Maryland

19. Date rec'd by registrar

June 13 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va.

County Monongailia

City or town Pursglove

(If outside city or town limits, write RURAL and give nearest town)

Street No. - - - - -

(If rural, give LOCATION)

2.(a) If veteran, name war - - - - -

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10

19

48

21

2:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-8

19

8

to

6-10

19

48

and that I last saw h.s. alive on

8-10

19

48

Immediate cause of death

Caecum of uterus

DURATION

4 yrs

Due to

Due to

Other conditions

Hypertension
cardiovascular disease

10 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

James Ellsworth Jr. MD

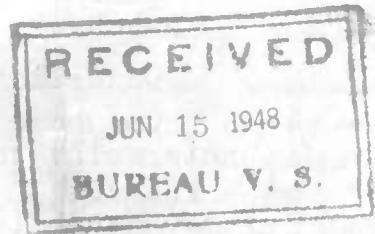
M. D. or other

Address

Piedmont W. Va.

Date signed

6-11-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5769

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M
e

1. PLACE OF DEATH:
 County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75-8-16
 Hospital, Institution, or street address where death occurred: Allegany Hospital
 How long in hospital or institution? 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 825 Mt Royal Av
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

3. (a) FULL NAME

Ella May Reinhart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Sept 29 1872

8. AGE: Years Months Days If less than one day

75 8 16 hrs. min.

9. Birthplace.....

Cumberland Md

(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business

At Home

12. Name.....

Francis Reinhart

13. Birthplace.....

Md

14. Maiden name.....

Mary A Downey

15. Birthplace.....

Md

16. Informant.....

Wm Reinhart

Address.....

Cumberland

17. Burial.....

Burial Date thereof June 27 48

(Burial, cremation, or removal Which?)

St Peter & Pauls

Cemetery or crematory.....

Cumberland

Location.....

Cumberland

18. Funeral director.....

Lomo Stern Inc

Address.....

Cumberland

19. Date rec'd by registrar.....

June 16 1948 W.R. Faust, M.D.

Registrar

83a

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 15 1948 at 7+

21. CERTIFY that death occurred on the date above stated; that I attended deceased from
I see. 19 48 to 15 June 19 48

and that I last saw h. 9 alive on 14 June 48 19 48

Immediate cause of death Cerebral Hemorrhage with
it. temporaryDue to Hypertension vascular
Diabetes?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

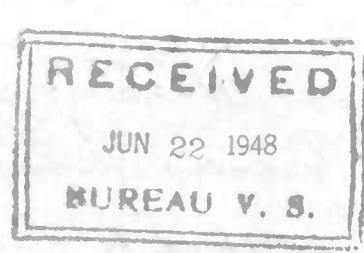
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Cleave

M. D. or other

Address Cumberland, Md. Date signed 15 June 48



Within corporate limits

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5770

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred: 519 Linden St

How long in hospital or institution?

3. (a) FULL NAME

Mary Margaret Robison

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife George W. Robison

7. Birth date of deceased (mo., day, yr.) February 2 1870

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

78 4 11 hrs. min.

9. Birthplace North Branch, Md Allegany County
(Town, county, and state)

10. Usual occupation House

11. Industry or business "

12. Name William W. Teeters

13. Birthplace Holidaysburg Pa

14. Maiden name Hannah Monett

15. Birthplace North Branch, Md

16. Informant Charles W. Robison

Address 519 Linden St. Cumberland, Md.

17. Burial Date thereof 6/15/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dans Run Cemetery

Location Ft Ashby, W. Va.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 14 1948 W. L. Fawcett, M.D.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W. Va. County..... Hampshire

City or town..... Greenspring
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7 1948 6-13 1948 to 6-10-48 1948

and that I last saw h E.Y. alive no 6-10-48 1948

Immediate cause of death Fracture of skull following

Fracture of skull following (Cause)

Due to Fall, n

Due to

Other conditions Osteoporosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Greenspring Drift, W. Va.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

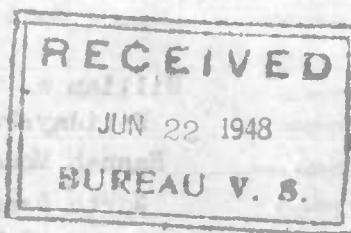
Means of injury Fall, f Injured at work? No

23. SIGNATURE J. R. Kight, M.D.

M. D. or other Romney

Address Date signed 13 June 48

STATE OF NEVADA
DEPARTMENT OF STATE
CERTIFICATE OF MAIL



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

73a

5771

9

Reg. Dist. No.....

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

Allegany
Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Munera hospital

How long in hospital or institution?

7 weeks

3. (a) FULL NAME

William Rodda

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**White**Single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

October 28, 1869

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

England

10. Usual occupation

*retired**shoe repair shop*

11. Industry or business

MOTHER FATHER

William Rodda

12. Name

13. Birthplace

England

14. Maiden name

15. Birthplace

Mary Hicks

16. Informant

17. Burial

18. Funeral director

19. Date rec'd by registrar

Address

Date thereof

(month)

(day)

(year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Address

Name

Date

Place

Time

Cause

Place

Date

Place

RECEIVED
JUN 18 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5772

47c

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

3.(a) FULL NAME

ROHRER, WILLIAM D. MR.

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

WEBSTER, MARY Clairbelle Shuck

7. Birth date of deceased (mo., day, yr.)

APRIL 23, 1873

6.(c) If alive, give age..... years

8. AGE:

75

1

25

hrs. min.

9. Birthplace

MARYLAND, Cumberland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

12. Name ROHRER, LORENZO

13. Birthplace Keedysville, Md.

14. Maiden name Catherine Webster

15. Birthplace Md.

16. Informant George L. Rohrer

Address 218 Columbia St., Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?) Cemetery or crematory Keedysville Cemetery

Date thereof June 27, 1948

(month) (day) (year)

Location Keedysville, Md.

18. Funeral director John J. Hoban

Address Cumberland, Maryland

19. June 27, 1948 John Hoban, M.D.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ALLEGANY

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 18, 1948

19.

2:40 P.M.

21. I certify that death occurred on the date above stated; that attended deceased from

June 15, 1948, to June 18, 1948, and that I last saw him alive on June 18, 1948.

Immediate cause of death

Chronic nephritis

? DURATION

Due to

Due to

Other conditions

Arteriosclerosis
Bronchogenic carcinoma

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

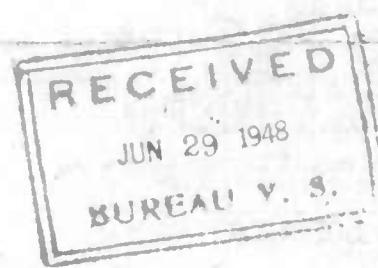
Injured at work

23. SIGNATURE

Homer S. Olson, M.D.

M. D. or other

Address Cumberland, Md. Date signed June 18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5773

CERTIFICATE OF DEATH

Reg. Dist. No. *138*

1. PLACE OF DEATH: **Allegany**
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **20 yrs**
 Hospital, Institution, or street address where death occurred: **Cresaptown, Md.**

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State **Maryland** County **Allegany**
 City or town **Cresaptown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1**
 (If rural, give LOCATION) **World War 1**

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Reginald (None) Rollings4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Divorced**6. (b) Name of husband or wife **Lula Smith**7. Birth date of deceased (mo., day, yr.) **Dec. 23, 1880** 6. (c) If alive, give age years8. AGE: Years **67** Months **.5** Days **21** If less than one day hrs. min.9. Birthplace **England**

(Town, county, and state)

10. Usual occupation **Retired Mill Worker**

11. Industry or business

12. Name **James Rollings**13. Birthplace **England**14. Maiden name **Charlotte Haddock**15. Birthplace **England**16. Informant **Mrs. Chester A. Wolfe**Address **Cresaptown, Md.**Burial **Burial** Date thereof **June 15, 1948**

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory **Rose Hill**Location **Cumberland, Md.**18. Funeral director **John T. Walford**Address **125 S Liberty**Date rec'd by registrar **June 15 1948** M. D. or other **M. V. Farnham**

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 12 1948** at **11:15 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Oct. 12 1947** to **June 12 1948** and that I last saw h. s. y. alive on **June 12 1948**.

Immediate cause of death

**Bi Lateral Pulmonary TB.
+ Tuberculous enteritis**

DURATION

3-4 years

Due to

Due to

Other conditions **Rheumatoid Arthritis****26 years**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

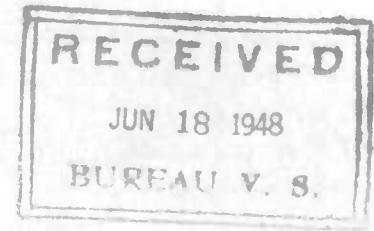
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **Zm T. Walford, M.D.** M. D. or other **M. V. Farnham**Address **Cresaptown** Date signed **6/15/48**



Within corporate limits
Dr. Weiss' office

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5774

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

Rt # 6

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs.

Hospital, institution, or street address where death occurred:

Allegany Hosptl

How long in hospital or institution? 1 1/2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town New Cumberland

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 Narrows Park

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

Helen Edie "Williams" Rosley

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Albert A. Rosley

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.)

October 15, 1895

8. AGE: Years

52

Months

7

Days

16

If less than one day

hrs.

min.

9. Birthplace

Roanoke, Virginia
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Own home

MOTHER FATHER

Name

George Williams

13. Birthplace

Unknown

14. Maiden name

Georgia Unknown

15. Birthplace

?

"

16. Informant

Mr. Albert A. Rosley

Address

Rt # 6 Cumberland, Md.

17. Burial

Date thereof June 4, 1948
(Burial, cremation, or removal, Which?)
(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hafer

Address

Cumberland, Md.

19. Date rec'd by registrar

June 4, 1948 W.R. Frank, M.D.

Registrar

MEDICAL CERTIFICATION

June 1, 1948 at 10:55A.M.

20. DATE OF DEATH

May June 31, 1948, to June 1, 1948

and that I last saw her alive on June 1, 1948

Immediate cause of death Hemoperitoneum

due to dissecting aneurysm of aorta

Due to: Idiopathic necrosis of the aorta

Due to: 1 1/2 days

Other conditions: Aortic atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

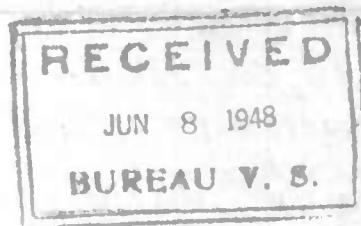
Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address: 122 Bedford St, Cumberland, Md. Date signed: 6/3/48

Non-syphilitic - 8/2/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5765

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Allegany, Md.

City or town... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, Institution, or street address where death occurred:

98 mt. Pleasant St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Dagmar Agnes Puckley

6. (c) If alive, give age years

T. Birth date of deceased (mo., day, yr.) Dec. 11 th. 1864

8. AGE: Years 83 Months 5 Days 20 If less than one day hrs. min.

9. Birthplace... Hagerstown, Allegany, Md.

(Town, county, and state)

10. Usual occupation... Retired Farmer

11. Industry or business

12. Name... John Jacob Puckley

13. Birthplace... Hagerstown, Md.

14. Maiden name... Sophie Litzky

15. Birthplace... Hagerstown, Md.

16. Informant... Mrs. Walter Beamer

Address 98 Pleasant St., Frostburg, Md.

17. Burial... Date thereof... Dec. 4-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Allegany Cemetery

Location... Frostburg, Md.

18. Funeral director... Paul D. Baker

Address... Frostburg, Md.

19. 6-3 1948 Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md.

County... Allegany

City or town... Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 98 Pleasant St.

(If rural, give LOCATION)

2.(a) If veteran, name war... ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1948 at 10:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 1948 to June 1 1948

and that I last saw him alive on May 31 1948

Immediate cause of death... acute Pyelitis

Duration... 2 weeks

Due to... Hypertension

Due to... Myocarditis

general yellow

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... M. D. or other

Address... Frostburg, Md. Date signed... June 2 1948

RECEIVED

JUN 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5775

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Albert C. Sandvik

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Catherine F. Hess Sandvik

7. Birth date of deceased (mo., day, yr.) May 26-1891 6. (c) If alive, give age 55 years

8. AGE: Years Months Days If less than one day
57 1 3 hrs. min.

9. Birthplace Eckhart Md. (Town, county, and state)

10. Usual occupation retired-coalminer

11. Industry or business

MOTHER FATHER 12. Name Andrew Sandvik

13. Birthplace Norway

14. Maiden name Catherine Eisentroudt

15. Birthplace Norway

16. Informant Catherine F. Hess (wife)

Address Eckhart Md.

17. burial Date thereof July 2, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery,

Location Frostburg, Md.

18. Funeral director J. R. Durst,

Address Frostburg, Md.

19. 7-1 1948 Mrs. Nancy H. Rose
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-09-6518

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 29 1948 at 11.50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive June 30 1948.

Immediate cause of death Chronic myocarditis with hypertrophy

DURATION 6 years

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

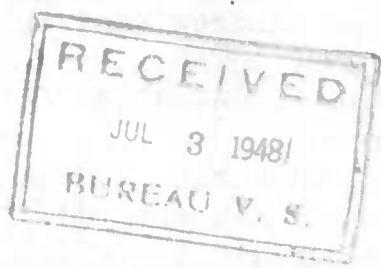
Deputy Medical Examiner - Allegany Co.

H. V. Deming M.D. H. V. Deming M.D.

M. D. - Other

Date signed 6-30-48





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5776

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Allegany

City or town Vale Summit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Annie B.

Schiller

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

W

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 29, 1865

6. (c) If alive, give age years

8. AGE:

Years 82

Months 11

Days 12

If less than one day

hrs. min.

9. Birthplace

Somerset Co., Pa.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Domestic

12. Name

John C. Schiller

13. Birthplace

Pa.

14. Maiden name

Anna Margaret Weinold

15. Birthplace

Pa.

16. Informant

William Schiller

Address

Vale Summit, Md.

17. Burial

Date of burial June 12, 1948

(month)

(day)

(year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Johnsburg

Location South Hampton Twp., Somerset Co., Penna.

18. Funeral director Harry H. Zeigler

Address Hyndman, Pa.

19. (Date rec'd by registrar)

19 48

Ms. Nancy V. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Vale Summit

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10, 1948, at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

10 June 1948, to 10 June 1948

and that I last saw her alive on 9 June 1948

Immediate cause of death cerebral hemorrhage

DURATION

Due to Hypertension

~~cardio~~

Due to

~~cardio~~

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Davis

M. D. or other

Address

110 Washington, Md.

Date signed 11 June 48

RECEIVED

JUN 14 1948

BUREAU V. S.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

5777

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs.
 Hospital, Institution, or street address where death occurred:
 861 Gephart Drive
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Allegany
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 861 Gephart Drive
 (If rural, give LOCATION)

3. (a) FULL NAME

JENNIE LEE SHERWOOD

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edwin A. Sherwood

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1869
 6.(c) If alive, give age years8. AGE: Years 79 Months 5 Days 15 If less than one day
 hrs. min.9. Birthplace: Booneville, Mo.
 (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

12. Name: John Rennison
 MOTHER FATHER

13. Birthplace: Unknown

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. H. C. Rainalter
 Address: 861 Géphart Drive, Cumberland,17. Burial: Date thereof: July 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Elmwood Cem.

Location: Kansas City, Mo.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. Date rec'd by registrar: June 26, 1948
 Address: W.R. Tracy, M.D.

Registrar

3. (b) Social Security Number
 None

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25, 1948, at 7:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 4-9-48 to 19-1948
 and that I last saw her alive on June 23, 1948

Immediate cause of death:

Bronic nephritis

Cerebral

Bronic myocardial
 degeneration

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: None

Date of op.: none

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W.F. Williams

M. D. or other

Address: Cumberland, Md. Date signed: 6-25-48

RECEIVED
JUN 29 1948
BUREAU V. S.

Whitman Corporate Drafts
Mr. & Mrs. Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5778

93d

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Allegany
County.....
Cumberland,
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hosp.

How long in hospital or institution? 33 days

3. (a) FULL NAME

CHARLES L. SIMPSON

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Ida A. Anderson

7. Birth date of deceased (mo., day, yr.)

Dec. 23, 1878

6. (c) If alive, give age..... years

8. AGE:

Years
69Months
6Days
2

It less than one day

hrs.

min.

9. Birthplace

Horse Shoe, W. Va.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

B. & O. Railroad

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. Walter Hazelrod

17. Burial

Address 111 Lennox Place Cumberland,

(Burial, cremation, or removal. Which?) Cemetery or crematory

Date thereof June 28, 1948 (month) (day) (year)

Mt. Zion Cem.

Location

Near Keyser W. Va.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.

19. (Date rec'd by registrar)

1948

June 26, 1948 C.R. Trautz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Allegany

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 219 Paca St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

705-09-7492

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 25,

19

48 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3, 1948, to June 25, 1948, and that I last saw him alive on June 25, 1948.

Immediate cause of death

Congestive heart failure

Due to chronic arteriosclerotic heart disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. Brings M.D.

M. D. or other

Address 59 Greene St.

Date signed 6-26-48

RECEIVED

JUN 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

McLane
5779

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 9

1. PLACE OF DEATH:

County

Allegany

City or town

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 Mt. Pleasant St.

How long in hospital or institution?

3. (a) FULL NAME

Thomas Francis Sleeman

3. (b) Social Security Number

214-01-1124

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Helen Sleeman

7. Birth date of deceased (mo. day, yr.)

May 11, 1879

6. (c) If alive, give age 68 years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Vale Summit

Allegany, Md.

(Town, county, and state)

10. Usual occupation.

11. Industry or business

Kelly Springfield Tire Co

12. Name

John Sleeman

13. Birthplace

England

England

14. Maiden name

Aureabellie

Watkins

15. Birthplace

Unknown

Unknown

16. Informant

Veronica

Sleeman

Address

Frostburg

Md.

17. Burial

Burial, cremation, or removal. Which?

Date of death June 25-48

(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg

Md.

18. Funeral director

J. R. Dirst

Address

Frostburg

Md.

19. Date rec'd by registrar

June 25 - 1948

Theresa Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

115 mt. Pleasant St.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 22

1948

at 139

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945

19...

to June 22

1948

and that I last saw him alive on June 21

1948

Immediate cause of death

acute Cardiac Dilatation

DURATION

2 hrs

Due to

Ch Myocarditis

6 mo

Due to

arterio sclerosis

several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

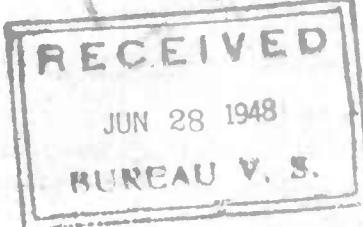
M. D. or other

Address

Frostburg

Md.

Date signed 6-23-48



PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468
Reg. Dist. No. 5780
9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteMarried

6. (b) Name of husband or wife

Annie Hayes Smith6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.)

Jan. 22 - 1888

8. AGE:

Years 66Months 4Days 27

If less than one day hrs. min.

9. Birthplace

New York, New York, N.Y.
(Town, County, and state)

10. Usual occupation

Shoe Dealer

11. Industry or business

Strips Springy Coal

MOTHER

FATHER

12. Name

Allegany Smith

13. Birthplace

New York, N.Y.

14. Maiden name

Mary Holmes

15. Birthplace

New York, N.Y.

16. Informant

Mrs. Thomas Smith

Address

4 Stager St. Frostburg

17. Burial

BurialDate thereof 6-21-1948

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

Jacob W. Price

Address

Frostburg, Md.

19. (Date rec'd by registrar)

6/21/48June 23, 1948Price

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

AlleganyCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Stager St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

396-01-8460

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 18 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 22 1948 to June 18 1948and that I last saw him alive on June 18 1948

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

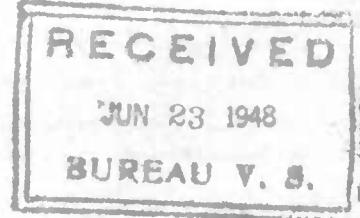
Injured at work?

23. SIGNATURE

H.C. Diehl, M.D.

M. D. or other

Address Frostburg, Md. Date signed 6/21/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line connect age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5781

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County

Allegany

City or town

Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Isabel S. Sparks

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Female

white

Widowed

6. (b) Name of husband or wife

Ernest A. Sparks

7. Birth date of deceased (mo., day, yr.)

May 31, 1872

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Mallows Mills

(Town, county, and state)

Md.

10. Usual occupation

housewife

11. Industry or business

William T. Saloway

MOTHER FATHER

Name

Maryland

12. Name

Hannah Stott

13. Birthplace

Maryland

14. Maiden name

Leroy Sparks

15. Birthplace

Eckhart Md.

16. Informant

Burial

Date thereof July 2, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Crumpton Cemetery

Location

Crumpton Md.

18. Funeral director

Louie Stein Inc.

Address

Cumberland Md'

19. 6 - 30

1948 Mrs. Xaviey V. Rice

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

Allegany

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION E.S.T.

20. DATE OF DEATH

June 29, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10, 1947, to June 29, 1948

and that I last saw her alive on June 22, 1948

Immediate cause of death

Teaching of

Segments of left hip

strain R.H. hip

Due to

Art Hernia

Hyperplasia

Osteoarthritis

Osteoarthritis

Duration

1 mo

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature

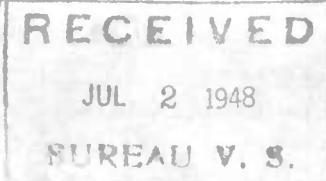
M. D. or other

Date signed

Address

Front Room

6-30-48



Dr. Dick Wm's

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

5782

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

24 years

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

4 Days

3. (a) FULL NAME

Mabel Wilson Spencer

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Ellis Spencer

7. Birth date of deceased (mo., day, yr.)

September 12, 1923

6.(c) If alive, give age years

35

8. AGE:

Years
24Months
8Days
10

If less than one day

hrs. min.

9. Birthplace

Cumberland, Allegany, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name

Levi Wilson

13. Birthplace

?

14. Maiden name

Agnes Winebrenner

15. Birthplace

?

16. Informant

Ellis Spencer

Address

421 Balto Ave., Cumberland, Md.

17. Burial

Cremation

Date thereof June 5, 1948

(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Maryland

18. Funeral director

John J. Hofer

Address

Cumberland, Md.

19. Date rec'd by registrar

June 5, 1948

W.H. Frantz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Allegany

City or town

Cumberland

Street No.

421 Baltimore Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

6/2/48

19

at 10 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/15/48 19 to 6/2/48 19

and that I last saw her alive on 6/2/48 19

Immediate cause of death

Myocardial infarction

due to

Hypertension Cyst

and Acute myocardial

and cerebral hemorrhage

DURATION

3 days

1075

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Vegetation on valves - Petechiae

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

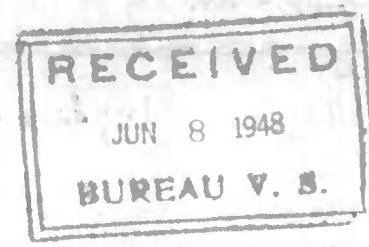
Injured at work?

23. SIGNATURE

B. H. Chapman, M.D.

M. D. or other

Address Cumberland, Md. Date Signed 6/8/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5791

159

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

ALLEGANY

CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

BABY GIRL STOUFFER, BARBARA ANN

None

4. Sex: FEMALE Color or race: WHTE 5. (a) Single, married, widowed, or divorced: SINGLE

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): 6/17/48

6. (c) If alive, give age: years

8. AGE: Years: Months: Days: If less than one day: hrs: min:

9. Birthplace: CUMBERLAND, ALLEGANY, MD.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

MOTHER FATHER: 12. Name: RAY STOUFFER

13. Birthplace: MARYLAND

14. Maiden name: WITTE, MARY E.

15. Birthplace: MARYLAND

16. Informant: Ray Stouffer

Address: CUMBERLAND, MD.

17. Burial: Date thereof: 6/18/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Hyndman

Location: Hyndman, Pa.

18. Funeral director: Harry H. Leyler

Address: Hyndman, Pa.

19. Date rec'd by registrar: June 8, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7, 1948, at: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6, 1948, to June 7, 1948,

and that I last saw her alive on June 7, 1948.

Immediate cause of death: Atletosis

Due to: press atelecty

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Tom H. McFarland, M. D. or other

Address: Cresaptown Md. Date signed: 7-5-48

RECEIVED
JUN 15 1948
BUREAU V. S.

8285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5783

157e
Reg. Dist. No. 9

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 days

Hospital, institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution?

2 days

3. (a) FULL NAME

Julia Jean Taylor

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, y.) June 11 1948

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

2 3 hrs. min.

9. Birthplace Frostburg Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Mary Elizabeth Taylor

15. Birthplace Frostburg Md

16. Informant Mary Elizabeth Taylor

Address Frostburg Md

17. Burial Date thereof 6-13-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jerome Taylor

Address 57 First St. Frostburg, Md.

19. 6-17 1948 Mrs. Harvey A. Roe

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg

Street No. 57 First St.

(If rural, give LOCATION)

2.(a) Is veteran, home war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 13 1948 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11 1948 to June 13 1948

and that I last saw her alive on June 12 1948

Immediate cause of death

Congenital heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

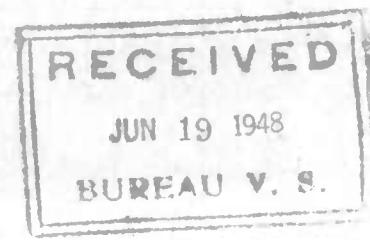
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Frostburg Md Date signed 6-13-48



DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b
5784

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M
The correct age

1. PLACE OF DEATH:
 County ALLEGANY
 City or town CUMBERLAND, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 DAYS
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State WEST. VIRGINIA County MINERAL
 City or town ELK GARDEN
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

None

3. (a) FULL NAME
 Sarah
 TICE, CARLISTA [REDACTED]

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced
 Widowed

6. (b) Name of husband or wife JOHN A. TICE
 JOHN A. TICE
 ELK GARDEN, W. Va.

7. Birth date of deceased (mo., day, yr.) October 17, 1872
 (month, day, year)

8. AGE: Years Months Days If less than one day
 75 3 7 520 hrs. min.

9. Birthplace WEST VIRGINIA, ELK GARDEN
 (Town, county, and state)

10. Usual occupation HWIFE

11. Industry or business ANDREW [REDACTED] Shillingburg

MOTHER FATHER 12. Name ANDREW [REDACTED]
 13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name EVANS, ANNA
 15. Birthplace WEST VIRGINIA

16. Informant Memorial Hosp.
 Address Cuyahoga Falls, Ohio

17. Burial Date thereof June 10, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory I.O.O.F. Cem

Location Elk Garden, W. Va.

18. Funeral director Rogers Funeral Home

Address Rogers, W. Va.

19. Date rec'd by registrar June 7, 1948 L.R. Fauntz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 7, 1948 at

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 7, 1948, to June 7, 1948,
 and that I last saw her alive on June 7, 1948.

Immediate cause of death

Due to Liposarcoma
 retroperitoneal

Due to Effloration of abdomen, 13 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Liposarcoma retro
 peritoneal Date of op. 5-25-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

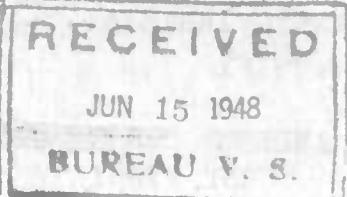
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

L.R. Fauntz, M.D. M. D. or other

Address Cumberland, Md. Date signed 6-7-48



Within corporate limits

DR FAW

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

5785

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 43 DAYS

3. (a) FULL NAME

MR. WILMER VANPELT

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE

WHITE

DIVORCED

6. (b) Name of husband or wife THELMA LE PLEY

6. (c) If alive, give age 39 years

7. Birth date of deceased (mo. day. yr.)

OCT 20, 1906

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

VIRGINIA Harrisonburg

(Town, county, and state)

10. Usual occupation

None Truck Driver
Chinese Corp.

11. Industry or business

MOTHER FATHER

12. Name VAN PELET, CHARLES

13. Birthplace VIRGINIA MARGARET

14. Maiden name S. MARGARET

15. Birthplace VIRGINIA

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVENUE

17. Burial Cemetery or crematory

Date thereof 6/8/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Fountain Cemetery

Location

Keyser, W. Va.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19. Date rec'd by registrar

June 7, 1948

(Date rec'd by registrar)

W.R. Frantz, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Allegany

City or town CUMBERLAND

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. RT # 3 VALLEY RD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-07-1949

MEDICAL CERTIFICATION

2D. DATE OF DEATH JUNE 5

1948, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June April 23 1948 to June 5 1948

and that I last saw him alive on June 5 1948

Immediate cause of death

Chronic glomerulitis - nephritis
hypertension

DURATION

6 yrs.

Due to Hypertensive heart
disease

8 yrs.

Due to

Other condition Terminal uremia

April 23 1948

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

No

Means of injury

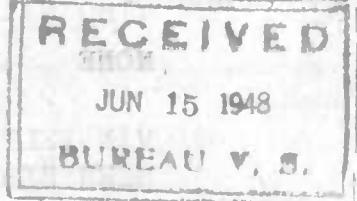
Injured at work?

23. SIGNATURE

W.H. Frantz, M.D.

M. D. or other

Address 5 Washington St. Court Date signed June 5, 1948



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5786

CERTIFICATE OF DEATH

94a
Reg. Dist. No. 6

1. PLACE OF DEATH: **Allegany**
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
Dawson
 How long in above place of death? **3 weeks**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
W. Va.
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
Mineral
 Street No. **35 North Church St.**
 (If rural, give LOCATION)
Keyser
 No
 2.(a) If veteran, name war.....

3. (a) FULL NAME **Walter Clinton Whistler**

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Widower					
Edna Jane (Davis) Whistler							
6.(b) Name of husband or wife.....							
7. Birth date of deceased (mo., day, yr.) Jan. 1880							
6.(c) If alive, give age years							
8. AGE: 68	Years	Months	Days	if less than one day	hrs.	min.	
Broadway, Va.			(Town, county, and state)				
9. Birthplace.....			El. Engineer B. & O.Ry. Co.				
10. Usual occupation.....			(Retired)				
11. Industry or business.....			Samuel Robert Whistler				
FATHER	12. Name.....			Virginia			
MOTHER	13. Birthplace.....			Frances Rebecca Todd			
	14. Maiden name.....			Ohio			
	15. Birthplace.....			Mrs. Wm. S. Caldwell			
	16. Informant.....			Keyser, W. Va.			
	Address.....			Burial XXX Queens Point			
				Date thereof.....	June 22, 1948		
	(Burial, cremation, or removal. Which?)			(month)	(day)	(year)	
	Location.....			Keyser, W. Va.			
	18. Funeral director.....			B. H. McLean			
	Address.....			Keyser, W. Va.			

19. Date rec'd by registrar.....

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 20** 1948 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan. 1948**, to **June 20, 1948**, and that I last saw him **alive** on **June 19, 1948**.

Immediate cause of death **Coronary thrombosis**

Due to **old arteriosclerosis**

Other conditions **arteriosclerosis acuta**

(Include pregnancy within 3 months of death)

Major findings of operations **None**

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **None** Date of _____

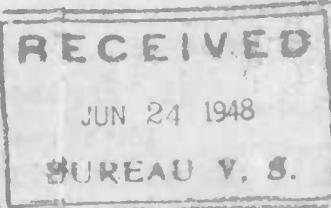
Where did injury occur? **Keyser, W. Va.** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE **J. H. Gifford M.D.** M. D. or other

Address **Keyser, W. Va.** Date signed **6-21-48**



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5787 Rozen

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

Allegany

City or town

Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 years

Hospital, Institution, or street address where death occurred:

Fayette St. St. Peter and Paul Monastery

How long in hospital or institution?

3. (a) FULL NAME

Rev. Fr. Benedict Joseph Wix

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age..... years

January 24, 1866

8. AGE: Years

82

Months

74

Days

7

It less than one day

hrs. min.

9. Birthplace

Pittsburgh, Penna.

(Town, county, and state)

10. Usual occupation

Priest

11. Industry or business

Roman Catholic Church

MOTHER FATHER

12. Name

Mark Knobler

13. Birthplace

14. Maiden name

Mark Knobler

15. Birthplace

16. Informant

Fr. Albin, Fayette St.

Address

Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 7, 1948

(month) (day) (year)

Cemetery or crematory

St. Peter & Paul's Cem.

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Maryland

19. Date rec'd by registrar

June 7, 1948

John Dautz, M.D.

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Fayette Street - Monastery

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

1948 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

4/1/48 to 6/1/48

and that I last saw him alive on

5/3/48

Immediate cause of death

Chronic myositis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John R. Rozen, M.D.
Cumberland, Md.

M. D. or other

Date signed

RECEIVED

JUN 8 1948

BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5788

Reg. Dist. No. 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:
MEMORIAL Hospital

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND Pa County COUNTY Somerset

City or town CUMBERLAND, Somerset
(If outside city or town limits, write RURAL and give nearest town)

Street No. West Union St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

6-19-48 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-22-49 to 6-23-48

and that I last saw her alive on 6-23-48.

Immediate cause of death

Ocular carcinoma
of Sigmoid with
Dysplastic nodes
metastases.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Name as above Date of op. 9-3-47.

None.

Date of op. 9-3-47.

Autopsy results None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

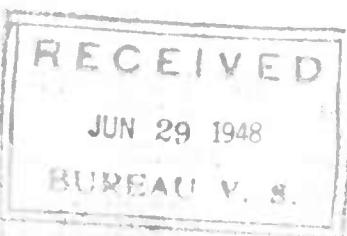
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Williams M. D. or brother

Address Cumberland Date signed 6-23-48



RECEIVED
JUN 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly.

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5790

FILM NO. G 116 JUN 22 1948 CERTIFICATE OF DEATH

93d

Reg. Dist. No.

9

1. PLACE OF DEATH:

County

City or town

Allegany

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

76 W. 200 St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

Conrad Youngerman

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

Dec. 22nd 1857

8. AGE:

Years

Months

Days

If less than one day

90

6

19

hrs.

min.

9. Birthplace

(Town, county, and state)

Frostburg Allegany Md

10. Usual occupation

Wife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

15

48

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